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ABSTRACT

The final report of a 3-year project designed to educate the community and train personnel in child abuse detection and treatment planning provides a chronological review of the project and a discussion of evaluation findings. The bulk of the document is composed of nine appendixes, including discussions of seven program components: training and education, parents anonymous (a parent self help group), parent aides, child trauma teams (a multidisciplinary approach to reporting and staffing child abuse and neglect cases), new parent information service, law intern program, and child management classes. (CL)

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# Parent and Child Effective Relations (PACER)

GRANT #90-C-82

## FINAL REPORT

Submitted by:

Charlene G. Bennett, A.C.S.W.
Juvenile Welfare Board of Pinellas County
St. Petersburg, Florida
Project Principal Investigator, Raymond L. Edwards, Ph.D.

Submitted to:

Office of Child Development
Department of Health, Education, and Welfare
Washington, D.C.

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(PACER)
Grant #90-C-82


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Parent and Child Effective Relations (PACER)
HEW Grant #90-C-82

Statement of Property Disposition

A. All permanent items purchased with Grant #90-C-82 funds have been retained at the Juvenile Welfare Board of Pinellas County, the sponsoring agency. The bulk of referenced items include audio-visuals and audio-visual equipment. All of these will receive continued usage in the Training and Education Unit's child abuse training functions. If you require an itemized listing or specific details about these items or their use, we will be happy to provide the additional information.

B. A variety of pamphlets, flyers, etc. that were either purchased by or produced with #90-C-82 funds remain. The Juvenile Welfare Board continues to distribute these upon request and as part of its current child abuse informational programs.

C. Office equipment purchased for use by project staff (desks, chairs, typewriters, files, calendars, etc.) are housed at the Juvenile Welfare Board; some are currently idle, some are utilized by the PACER staff which remained employed at the Juvenile Welfare Board, and some are in use by the staff of our Youth Services System Advisory Council.

D. Miscellaneous leftover supplies, resource materials, etc. continue in use at the Juvenile Welfare Board, primarily by training staff. Outdated resource materials were donated to the Juvenile Welfare Board Holland Child Welfare Library for community use.

E. All files and records of the PACER operation are retained at the Juvenile Welfare Board and are readily available for use or inspection. Training staff use them for responding to inquiries or consultation requests relating to PACER activities. We will retain these for 5 years (in compliance with Florida law) unless a longer period is stipulated by HEW.

FINAL REPORT

Parent and Child Effective Relations (PACER)

Juvenile Welfare Board of Pinellas Co.

St. Petersburg, Fla.

I. Project Identification Number: 90-C-82

II. Project Title: Parent and Child Effective Relations

III. Project Director: Charlene G. Bennett, A.C.S.W.
Principal Investigator: Raymond L. Edwards, Ph.D.
Report Preparation: Charlene G. Bennett

IV. Purpose and Objectives of Project:

A. The original Goal and Objectives of PACER read as follows: The overall goal of the proposed Parent and Child Effective Relations Project (PACER) is to significantly reduce the incidence of child abuse among Pinellas County families and to achieve this by maintaining the child in his natural home whenever possible. Tasks of the project include:

1. To improve case finding by special training of school, social service agency and other personnel who have frequent contact with Pinellas youth.

2. To improve case finding and care and treatment of both children and their parents by development of hospital based inter-disciplinary child trauma teams.

3. To improve the data base regarding abused children at the hospital level so as to lessen the possibility of error regarding diagnosis.

4. To assess the cost of hospital care of abused children and their families.

5. To offer abusing parents additional opportunities of treatment, thereby minimizing removal of children from the natural home.

6. To improve the overall data base regarding the subject of child abuse so as to facilitate improved prevention, detection, and treatment of the condition at the county and possibly state and national level.

B. In early 1975 we began reviewing goals and objectives because there was some staff confusion and some goals appeared inappropriate for a 2½ year project. Efforts on the part of staff, Juvenile Welfare Board Community Services Team, and Berkeley Planning Associates resulted in the following revision dated June 1975:

Primary Objectives

1. To provide educational programs and community information aimed at the public in general and at high risk groups in particular.

2. To provide training programs for professionals and paraprofessionals for the purpose of increasing their knowledge of child abuse/neglect and of their professional responsibility.

3. To enhance case finding and treatment planning for both children and their families through the development of child trauma teams, a law intern program, and a child trauma medical registry.

4. To develop new treatment services for identified abusers/neglectors and potential parents at risk, including Parents Anonymous and Parent Aides.

5. To initiate a procedure for early identification of high risk families and a method for follow-up and referral to service resources.

Secondary Objectives

1. To provide the impetus for a co-ordinated community system of combined preventive and corrective efforts aimed at minimizing child abuse and neglect in Pinellas County.

2. To improve the overall data base regarding the subject of child abuse so as to facilitate improved prevention, detection and treatment of the condition at the county, state, and possibly national level.

3. To assess the cost of hospital care of abused children and their families both before and after the establishment of child trauma teams.

V. Chronological Description of Program

The brevity requirement for this category will be difficult since a significant volume of activity occurred in PACER and steady change was experienced. Background, history of project development, and detailed plan of projected operation are all included in the original project document. Detailed reports of the evolution of the project and its components are contained in the routine reports which have been submitted during the course of the project; those are filed with you in documents entitled Monthly Reports, Quarterly Reports, and Funding Re-applications. Details of the model program components are attached as appendices as requested. This chronological summary of those materials cannot capture the reality of the project and is by definition superficial.

A. Months 1 - 3

During this period, all staff were hired and oriented; they were Project Director, Assistant Project Director, 2 Program Coordinators, Project Secretary, and Statistician. Task assignments were made, component development outlined, and implementation begun. During this start up period, alterations were made in components and in staffing patterns. Significant component changes included:

1. Abandonment of original plan to hire legal investigators because legal mandate lies with another agency. Substituted with a plan to supplement State Attorney's office in return for their commitment to represent Protective Services in court cases.

2. Abandonment of original plan to contact parents of newborns because of limited number of staff and lack of legal mandate to investigate child abuse. Made plans to modify component and locate it in a maternity ward.

This period contained our initial site visit from our researchers, Berkeley Planning Associates and laid the groundwork for the additional seven such visits and for ongoing data collection. Staff also began establishing relationships in the community

and identifying problem areas needing attention, such as legislation revision, lack of coordination, specific training needs, etc.

B. Months 3 - 6

It should be pointed out here that PACER was begun approximately six months late and the first year referred to herein is actually a six-month period. Progress by the end of the first year was outstanding in some areas and disappointing in others. While it had originally appeared that establishment of a Child Trauma Team at All Children's Hospital would represent our first completed component, problems developed and the component was not yet operational. By this time we had recognized that one of our two major problems was resistance on the part of the medical community; not only was it delaying team development, but it was diminishing hope for a Central Medical Registry. Alternative routes were attempted with revised goals aimed at developing one team and depending upon it to later stimulate a registry, as well as other teams. For the same reasons, we were having no success in gaining the cooperation of a maternity ward for purposes of a high-risk detection effort. Our own Advisory Council was also resistive and necessitated a defensive restructuring of this component with the ultimate result of an exceptionally well received component, which we entitled New Parent Information Service.

The Legal Intern program was functioning at full capacity, and our training and education efforts were beginning to impact the community. After initial difficult hurdles we were gradually permitted by the community to provide both professional and community education. It was in this area that we first experienced our second major problem: resistance and distrust on the part of the protective services agency, Health and Rehabilitative Services. The training and education effort was capped off that year with a major community seminar which, for the first time, facilitated some effective communication with HRS and a few members of the medical community; this represented a turning point and kicked off a very successful second year for PACER.

The first year saw growth and smooth functioning of our three service components, Parents Anonymous, Parent Aides, and Child Management Classes. Because these three relied primarily on staff for development with minimal input from others, these three were more easily operationalized than other components. All experienced good reception from the community except that they were subject to the HRS hesitation and were seldom the object of referrals from that particular agency.

This year of course involved establishment of management procedures, as well as miscellaneous staff activities such as committee assignments, consultation, coordination endeavors, and participation in alteration of our state child abuse statute. The Research component was also underway in the form of data collection, although it had become evident that some desired community data either was not available or could not be retrieved. The afore-mentioned goal revision had also occurred.

By the end of the first year components were finalized for the remainder of the Project's life; they are as follows:

1. Service Components
   a. Parent-Aides
   b. Parents Anonymous

2. Corrective Components
   a. Family Consultation Team (Child Trauma Team renamed)
   b. Legal Intern Unit

   (Notation: the Medical Registry component was never activated)

3. Preventive Components
   a. Training and Education
   b. New Parent Information Service

4. Research

5. Other Activities
   All those other activities of an on-going or periodic nature, the most significant of which was to be coordination. It also became necessary to remove Child Management classes from Service component listing and list it under Other because its unresearchability rendered it ineligible for component status.

Looking back we remember how frustrated we felt at the end of year one, but in retrospect it is clear that we had accomplished a remarkable amount of work during those six months.

C. Year Two

All components operated during this year at maximum levels and the project seemed to flourish in this year. Headway was made in the major problem areas and gratification was abundant in the area of finding alternate success routes when main highways were blocked. We became highly visible in the community, and many components achieved status on their own merits. We like to think that we made some small contribution to the decreased reported rate of child abuse in Pinellas County this year.

Impetus provided by the seminar already mentioned quickly led to implementation of the Child Trauma Team at All Children's Hospital and to planning sessions for an up-county team. That same seminar triggered incidents which comprised the metamorphosis of maternity ward monitoring into the New Parent Information Service. Our training and Education Component seemed to explode after the seminar with considerable demands on our time for both professional and community education. The medical community responded and training sessions were conducted in all major hospitals. Even Health and Rehabilitative Services began putting out feelers which eventually led to their extensive use of training in the third year.

Service components, corrective components, and preventive components all progressed and many stumbling blocks were circumvented. Staff was active in the community in many ways. Our budget was allowed a little expansion, which provided quite adequately for second year needs. Details of these components are included in the appendices and also in the material prepared by Berkeley Planning Associates. We left this year sailing high and quite pleased with our accomplishments. It was soon to become quite a contrast to the last year.

D. Final Year

Once we entered the final year, the consciousness of that fact was seldom distant and it colored performance. Various staff decathected, or attempted to, at various times, and depression was sometimes individual, sometimes staff wide. Contact from Washington seemed to disappear, and a sense of isolation set in. The necessary budget cuts set a downhill trajectory, which was occasionally interrupted, but never halted. The phaseout was premature in some components because of budget cuts and unwelcome at all times. Corrective components fared better in terms of spin-off. The Family Consultation Team was strong enough to continue on its own steam and required only reorganization. The Legal Intern program was discontinued, but the program's goal was achieved, that is, the State Attorney's office will continue to represent protective services, even though the interns will no longer function.

The Service Components were phased out as follows:

Parent Aides: This program was tapered all year to prepare for the worst - no spin-off. And the worst happened. Although there was more interest in this component than in any other, and community persons made an effort to find a solution to continuity, disintegration did occur. We understand, however, that it is included in the protective services budget for 1978, and we are hoping that it will be approved.

Child Management Classes: This was essentially spun off long ago. The Adult Home Economics in the Pinellas School System will be continuing these classes.

Parents Anonymous: After some faltering and confusion which resulted in temporary cessation of services, the down-county Parents Anonymous group was revived by the JWB Marriage & Family Counseling program, and they will continue to sponsor the group.

Preventive Components survived at fifty-fifty. New Parent Information Service is expensive and was not picked up. The Juvenile Welfare Board continued the Training and Education by hiring two of the staff into its Training unit to provide comprehensive training for children's services in Pinellas County. In the area of Research, all data collection was completed and forwarded to Berkeley Planning Associates. Results of their extensive analysis of our data and project should be available in the next few months. Coordination and miscellaneous areas continued to be addressed throughout year three.

The last few months of the project were very difficult for all. The only component which continued at full pace was Training and Education, which experienced major successes in the final year, including training of HRS staff and providing impetus for growth of their own training staff. Diminished enthusiasm struck us all and reached oppressive depths. The job search of some staff members was painful and some were still unemployed at the termination of the project. Although that final year was an experience none of us would choose to repeat, it did have gratifying moments; numerous community and professional persons bothered to tell that they appreciated our efforts, lamented the forthcoming cessation, convinced us that we had made a significant impact, and provided some assist in the area of job hunting.

PACER's official termination date was June 30, 1977.

E. Dissemination.

The updating which we have regularly provided includes all necessary information about dissemination that occurred during the course of the project. At this point, brief information about the project as a whole or detailed material about the development of specific components is provided all inquirers upon request. With no money left, we cannot afford to duplicate this final report except in situations where the real likelihood of service benefit seems clear. Betty Royer and I provide consultation where feasible, and we will provide ongoing dissemination in the form of child abuse education. We do not have knowledge of dissemination plans for the extensive material which has been and is being prepared by Berkeley Planning Associates, but hope that we will be supplied with that information.

I do plan to write another report on PACER - a community organization model approach. We will probably attempt to publish it and will forward a copy to you when completed.

Although PACER staff made many presentations on child abuse and related issues, we have very few written speeches, etc. to forward. We usually spoke extemporaneously or from notes only. What is available is not all in finished form, but it is attached as is in Appendix I.

VI. Model Program Components

Our project and components were summarized in a brochure which we used for informational purposes. A copy of that brochure is attached here as a way of providing the brief component description. Detailed component description, as prepared by the individual staff persons responsible for the respective components, are attached as Appendices A through H.

PACER
PARENT AND CHILD EFFECTIVE RELATIONS

juvenile welfare board of pinellas county 813/822-6661
3455 first avenue south • st. petersburg • florida 33711

executive director
Raymond L. Edwards, ACSW, Ph. D.

project director
Charlene G. Bennett

## CHILD ABUSE INTERVENTION: A PREVENTIVE APPROACH

PACER is a three year demonstration and research project, funded through the Department of Health, Education & Welfare, sponsored by the Juvenile Welfare Board, and designed to significantly reduce the incidence of child abuse among Pinellas County families. Nationally, over 500,000 incidents of child abuse are reported annually. In 1975, 2,017 cases were reported in Pinellas County. This figure exceeds the national child abuse reporting rate by forty per cent. Experts believe, however, that only one tenth of the actual child abuse cases are reported. PACER is attempting to reduce the incidence of child abuse in Pinellas County through a preventive and supportive effort in strengthening the ability of families to care for and nurture children whenever possible. PACER's components are directed toward intervention in the cyclic pattern of child abuse. PACER program components are:

Training and Education
Parents Anonymous
Parent Aides
Child Trauma Team
New Parent Information Service
Law Intern Program
Data Collection and Project Evaluation
Child Management Classes

## TRAINING AND EDUCATION

It is not the intent of PACER to duplicate existing child abuse services. We are, however, seeking to stimulate interest in developing needed services and enhance coordination within exsting programs. It is our hope that PACER will be used as a tool in the development of new as well as improved services to the abusive family and abused child. PACER staff is available to assist community organizations and agencies to expand their awareness in the area of recognition, prevention, and treatment of child abuse. Our training programs for professionals have been accredited by several professional groups for continuing and in-service education. PACER has a Speaker's Bureau and can provide a speaker for service organizations and community groups on request. We have a comprehensive child abuse library of audio visuals and training materials which are available to individuals and community groups on a loan basis.



PACER is made possible through a grant from the Office of Child Development, 

## PARENTS ANONYMOUS

A self help group for parents who fear that they may abuse or who are actually abusing their children. Abuse is defined as physical, sexual, verbal, and emotional abuse, while neglect may be either physical or emotional.

PACER has two chapters of Parents Anonymous in Pinellas County. One is in St. Petersburg and the other is in Clearwater. Child care is provided at the weekly meetings. For further information regarding meetings, call 822-6661.

## PARENT AIDES

Volunteers assisting families in relieving stress before reaching crisis. On-going training and supervision by PACER staff support parent aides in their efforts to prevent child abuse. "Parenting the parent" is the focus of this component of PACER. Helping the parents can lead to stronger family life, thus alleviating potential danger to children. Further information about the parent aide program or information about volunteering for this component can be secured by calling PACER.

## CHILD TRAUMA TEAM

An interdisciplinary approach to diagnosis and case treatment planning, hospital trauma teams provide better communication methods and coordination of case planning, provide stimulus for development of other services, and involve professionals who were previously peripherally involved in the problem of child abuse. The down county Family Consultation Team is located at All Children's Hospital, and an up county team is in the planning stage.

## NEW PARENT INFORMATION SERVICE

Volunteers from the community are recruited and trained as family interviewers in a special twelve hour workshop. Interviewers infrom parents with new babies about available community services and provide special assistance to those families in need of services.

## LAW INTERN PROGRAM

In cooperation with the State Attorney's Office, Stetson University Law School, and District V of the Florida Department of Human and Rehabilitative Services, law interns are helping the State Attorney's Office prepare affidavits in contested cases of child abuse and neglect.

## DATA COLLECTION AND PROGRAM EVALUATION

Compilation of statistical and analytical data on national, state, and local levels. This component also includes evaluation mechanisms to evaluate the effectiveness of PACER over the three year operation period.

## CHILD MANAGEMENT CLASSES

One of the follow-up services which is available in co-operation with Adult Education Division of Pinellas County School System are Child Management Classes. Classes deal with promoting positive and healthy interaction between parents and children. Classes are open to parents of infants and toddlers as well as older children.

## PACER STAFF

Charlene G. Bennett, Director

Carol J. Nofen, Assistant Director

Nadia Conitz, Project Secretary

Margaret C. Williams, Program Coordinator

Elizabeth Royer, Program Coordinator

Thom Shuman, Planning Technician

## VII. Evaluation

PACER'S original evaluation plan is contained in the initial grant proposal. That was written, however, prior to the involvement of Berkeley Planning Associates in researching the eleven joint demonstration projects. We have regularly received data compilation findings from BPA, but do not have their final evaluative data. We ask you to refer to that upon receipt. The data collection activities performed specifically by PACER are included in the report of the Research component in Appendix H.

Obviously, there is little data-based evaluative material ready as of this writing. Therefore, we will include just a few of our impressions based on the project experience.

1. Educating Professionals. This seems best done via back door approaches, mainly by asking their assistance in problem solving endeavors and thereby exposing them to new knowledge and understanding. One effective approach we used was to ask unqualified professionals to be on panels, etc. so that they were impelled to do research, were exposed to keynote speakers, and then felt obliged to pass on their new knowledge.

2. Change. Change in protective services follows a pattern. The thinking of anyone exposed to the child abuse problem progresses along the following steps:

    a. Anger
    b. "Getting even" and "righting wrongs"
    c. Protecting children
    d. Helping parents
    e. Helping children
    f. Helping families
    g. Involving families in decision-making process and developing supportive services
    h. Emphasis on prevention

    People do not skip from one stage to the next; they must experience each to reach the next. Some persons move fast and some slowly, but a community as a whole moves at a fairly predictable pace once its initial impetus has begun. Federal mandates can help speed the process only slightly, and they can backfire as often as help. The federal leadership and assistance should be available; communities will partake when their capacity dictates. The federal government could also help by arranging knowledge trades between communities.

3. PACER'S Impact

    a. PACER impacted the community by raising its professional and lay awareness of child abuse. It gave impetus to and encouraged progress along the steps mentioned in #2. Interestingly, the agency which displayed the greatest resistance, protective services, was the one which had made the greatest strides by the end of the project. They were switching gears in the use of long term foster care, securing permanent commitments, introducing contracting, beginning to think in terms of services to families, and moved from having no training to establishing a training unit. The movement in the community toward better protective services is now clear.

    b. PACER provided some services not heretofore available in the community. These were not readily accepted, and some are only now gaining status

because someone else is attempting to find a way to provide it. This gets to the trust issue, which will not soon be solved. However, I believe these services at least got introduced sooner than they would have without PACER.

c. PACER facilitated a new emphasis on prevention. We demonstrated some prevention in the training and education and NPIS components, instead of talking prevention only. This has helped to create more of an it-can-be-done atmosphere. Time will tell, but I am convinced that this community will be doing significant prevention long before many others.

d. I do not feel that we effectively demonstrated that operating outside the established legal system is preferable to any other. There are pros and cons and not enough comparative data is available to make a judgement about this.

e. PACER'S main goal of reducing the incidence of child abuse was only dented and data will no doubt prove insufficient to attribute the decrease to PACER. This and all other goals are part of the BPA research; they have the data for analysis. We are anxious to discover what, if anything, is reached in the way of final conclusions relative to our goals.

f. We are not enthusiastic about the use of demonstration projects in the field of child abuse. The time is short, projects get started late (as did ours), it takes time to get into top gear, and the last year is not exemplary because of the hanging threat of termination. Research is inadequate, there is no guidance, and apparently there are not always summative reports. I would doubt any summative report of terminated projects anyhow because of the staff depressions or absence which limit the presentation. E.g., I, normally a prolific writer, have a marked distaste for writing this report, and one should wonder about its quality therefore. Also, it does not help when past experience leads one to suspect that the interest in these reports will be minimal, the use of them negligible. In fact, we cannot help but wonder if they do indeed get read.

Innovation will occur without the federal government. Why not spend your money on research and dissemination of existing programs rather than creating artificial ones? This, of course, would still be secondary to footing the bill for direct services to start with, i.e. substituting just a few major weapons for improved human services.

VIII. Recommendations

This item is unclear to me. I do not know if we are being asked for broad recommendations, recommendations specific to child abuse, or recommendations specific to this project. I am making a guess in favor of the latter and will proceed from that reference point. As of the termination of PACER, our recommendations are as follows:

1. The components should be spun off in this way:

a. Parent Aides. Should be picked up by protective services or Family Counseling Center. Both have considered it, as have other agencies; several have plans to pursue it. However, the most likely is protective services, and this thrust should be encouraged.

b. Parents Anonymous. Should be outside mandated system. Recommend Family Counseling Center, but no demonstrated interest. Marriage and Family

Counseling has volunteered and accepted responsibility as of this date.

c. Child Management Classes. Continue in school system and be supplemented by any and all organizations capable of handling them; the need for neighborhood-based endeavors is clear.

d. Legal Interns. Goal accomplished; no need for continuation.

e. Child Trauma Teams. Continue at All Children's and wait until up-county hospital is more receptive. Needs strengthening through stronger leadership, but we do not know where this might come from.

f. New Parent Information Service. Should be incorporated into an overall prevention package in this county. Needs to be attached to long-term research to determine its usefulness.

g. Training and Education. Continue at JWB (in effect) with gradual transfer to HRS. HRS has a training unit now which is beginning to do child abuse training; we will encourage and assist in all possible ways.

2. Related recommendations are as follows:

a. There is now a standing committee of our Youth Services System Advisory Council for Abuse, Neglect, Dependence. That committee plans to develop an overall child abuse plan for the county with emphasis on in-home services; it should also develop a prevention package which would include such components as:

- Hospital related programs which facilitate parent-child bonding
- Parent Education models
- New Parent Information Centers and Clinic
- Crises Teams
- Drop in centers
- Parental Stress Hotline (negotiations underway)

b. A comprehensive primary prevention program should be developed for this community. It would include the above items, but would also be inclusive of a complete educational package and a restructuring of financial resources to attack poverty and stress-related issues.

# APPENDICES

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APPENDIX A

Training and Education

## Training and Education Component

The Training and Education component of PACER was the largest component, both in terms of PACER staff involvement and thrust and visibility in the county. Although one staff person had major responsibility for planning and coordinating the training component, all five professional staff members participated in training and educational activities.

PACER had five primary objectives and two of these objectives were:

1. To provide training programs for professionals and paraprofessionals for the purpose of increasing their knowledge of child abuse and neglect and of their professional responsibility.

2. To provide educational programs and community information aimed at the public in general and at high risk groups in particular.

An analysis of referrals to the state wide child abuse Hot Line over a two year period (1972-1974) indicated minimal professional reporting. Physicians reported about one percent of the cases state wide, and the reporting by all health professionals was four percent of the total reports. In view of the low reporting rate by health professionals, physicians and hospitals were targeted for professional training during PACER's first year of operation.

A fair degree of success was achieved in stimulating hospitals to have a child abuse training program for emergency department personnel and pediatric staff. Six of the eight hospitals in the county had in-service sessions, varying in length from two hours to an all day seminar at one of the largest hospitals in Pinellas County. Four of the six training sessions were approved for Continuing Education credits by the Florida Nurses Association.

The hospital child abuse sessions were held in the hospitals and attended chiefly by nursing personnel with a scattering of physicians. Times of the sessions varied. One hospital preferred a comprehensive child abuse unit which consisted of four two-hour sessions during four consecutive weeks for all three shifts, which meant repeating each session three times at 7:30 a.m., 3:30 p.m. and 11:30 p.m. Employees were paid overtime to attend after shift duty. Probably the most successful hospital training session was a three-hour session (7 to 10 p.m.) which was attended by 175 persons from all shifts.

Hospitals were responsive to having child abuse training sessions. Accreditation site visits by the Joint Commission on Accreditation of Hospitals had included the lack of a child abuse reporting procedure as a deficiency in two of the hospitals. One fairly large hospital in an up-county upper middle class area saw no need for any child abuse training as there is no abuse in that community, and no abused children are ever seen in the Emergency Departments, despite newspaper reports to the contrary.

Planning for the hospital training was done cooperatively with PACER staff and staff development personnel of the hospitals. PACER's audiovisuals were used in the sessions, and after an initial hospital session, the audiovisuals were subsequently borrowed by some hospital staff development personnel for ongoing child abuse training throughout the remainder of the demonstration project.

Of all the health professionals, the physicians were the most difficult to involve either in training or active participation in programing. The Pinellas County Medical Society co-sponsored all three of PACER's community child abuse seminars, and Florida Medical Association approval for continuing medical education credits was received for these seminars. In an attempt to get physicians involved in these community seminars, they were asked to serve as workshop leaders, presiding persons, or panel participants. When the Denver team from the National Center for Prevention of Child Abuse and Neglect led the first community seminar,

arrangements were made for Bart Schmitt, M.D. to meet with the medical staff at All Children's Hospital. The second seminar, which had Eli Newberger, M.D. and Robert ten Bensel, M.D. as leaders, was held in two hospitals to attract health professionals in general and physicians, specifically. Physician attendance at these two activities planned exclusively for physicians was minimal.

The Pinellas County Medical Society provided no leadership for any child abuse activity in the county. The executive, when asked, usually tried to meet PACER's requests (i.e., a panel member or a workshop leader). PACER staff was able to interest one pediatrician who was very supportive to the whole program, became involved in the child trauma team, and in general was a real "believer" in PACER's child abuse components.

A complimentary copy of "The Abused Child Primer" by Donald Phillip, M.D., with an enclosure letter indicating the availability of Juvenile Welfare Board staff for continuing child abuse training after the termination of PACER, was sent to all the hospitals and emergency physicians in the county.

During PACER's second year of operation, the schools were targeted for the major area of professional child abuse training and education, and much progress was made. This was due to a combination of factors. The overall community climate and readiness of school personnel to talk about child abuse and the teacher's professional responsibility in identification of abuse, plus a committed supervisor of school social work [illegible] was very instrumental in working toward acceptance of child abuse training from within the system.

Pinellas County has one public school system, involving 92,000 students and 112 schools, which made PACER's education and training efforts with the schools somewhat less complicated; not in terms of numbers of staff or students, but only having to deal with one school system and its myriad of policies and procedures.

Education and training with the Pinellas County Schools developed concurrently in three areas:

1. Adoption of an official child abuse policy statement by the School Board.

2. Professional training of individual school faculties on identification of child abuse and the educator's professional responsibility in child abuse.

3. Student presentations.

Work was begun with Administration toward School Board adoption of an official child abuse policy. Although the School Board has not adopted an official policy as yet, progress has been made in the area of receptivity of such a policy. Copies of child abuse statements adopted by school districts throughout the country were secured by PACER and provided to school administration. Major responsibility toward accomplishment of this objective will be with the schools, facilitated by some concerned supervisory and administrative staff. Each school in the system has its own reporting procedure and at the time of school faculty training sessions, it was evident that teachers were not always aware of the reporting procedure. The biggest variation in the different schools' reporting procedure was who, within a specific school, had responsibility for actually making the child abuse report. It was thought that some of this confusion would be resolved if an official overall policy was adopted.

High priority by PACER staff was given to professional training of classroom teachers in basic child abuse information, including identification of abuse, professional responsibility, the Florida child abuse law, what happens after a report is made, and case management. A six hour child abuse component was developed by PACER staff and accepted by Staff Development for inclusion in the Master Plan of the Pinellas County Schools.

After the child abuse component was included in the school master plan, the school social work staff was most helpful in making some of the initial contacts with individual schools. The most positive responses were from the elementary schools, where training sessions lasted from one hour to six hours. The overall format varied from session to session, but probably the most successful sessions were those that combined didactic presentations, panel discussions involving the principal, other supportive school personnel, and protective services, followed by adequate discussion time. About one third of the elementary school faculties received training, five middle schools, and no high schools.

The faculty training sessions apparently "whetted the appetites" of some educators, as it was noted there was a marked increase in teachers and supportive school personnel's attendance at PACER's subsequent community seminars and training activities.

One common concern expressed by educators at all job levels was their anxiety regarding reporting and their willingness to get involved. Some principals expressed concern that their school might have some negative community relations if they made too many abuse and neglect reports.

Class presentations to students on child abuse and neglect were fairly easy to facilitate as soon as PACER's Training and Education component became operational. Most of the class presentations in the public schools were made to high school classes (ninth, tenth, eleventh, and twelfth grades). During PACER's third year, a significant number of middle school (sixth, seventh and eighth grades) class presentations were made. In one middle school, PACER staff met with the entire (1,200) student body in groups of 40 students. These were scheduled over a period of a week.

Most of the class presentations were for one class period, although some presentations were planned for two and three classes, and in one high school a ten day child abuse unit was planned with a home economics teacher.

About half of the class presentations were made to home economics classes and the other half were made to social problems, psychology, sociology, law, and religion classes combined. Discussion in these classes was more stimulating, heated, and thought-provoking because these classes had both boys and girls. Home Economic classes basically had only girls. This limited "give and take" discussions around changing sexual roles in parenting.

There is one junior college, with three different campuses in Pinellas County. On a regular basis, class presentations are made on all the campuses in the following programs: human services, early childhood education, law enforcement, ecology, social sciences, nursing, and medical sciences. Staff acceptance at the junior college was quickly accomplished, and during the time of the project, much staff time was spent at the junior college. In addition to presentations, PACER staff was used as a resource for student child abuse projects, and PACER's child abuse audiovisuals are borrowed for use on college campuses very regularly. PACER staff, at less frequent intervals, participated in classes at the University of South Florida on the Tampa and St. Petersburg campuses, giving class lectures in both undergraduate and graduate courses.

In summary, the student presentations which were followed by group discussion were a very effective tool in public information and education about child abuse and neglect, whatever the student level.

Law enforcement child abuse training was more difficult to accomplish. Pinellas County has 23 different law enforcement agencies. All of the officers receive their training at the Police Academy, where four hours of child abuse training was incorporated into some of the classes with mixed results. No attempt was made to contact all the police departments individually for training sessions. Probably the most challenging, traumatic, fun, scarring and stimulating training sessions done during PACER's tenure were those with the entire

Clearwater Police Department, with three four-hour training sessions with 125 officers in groups of forty. A small number of the sheriff's deputies were involved in one training session, and there was minimum interest in training sessions displayed by other police departments. During the last year of the project, a series of ten six-hour community wide training sessions were held. The audience was a multi-disciplinary group in each session, and there was a sprinkling of law enforcement officers in the sessions. In general, with very few exceptions, attitudes of the law enforcement officers were fixed, punitive, and difficult to change.

Day care staff training sessions were held for Head Start centers, Project Playpen day care homes, License Board homes, the Child Care Association, and some private preschool centers staff. For the most part, the training was done as part of planned staff development programs. Some child abuse programs were presented to parent groups of the varied early childhood education facilities. At their request, a four-hour professional seminar was developed for the Pinellas Chapter of the Association of Childhood Education, whose membership is composed of professionals.

A brochure announcing PACER's Speakers Bureau was developed and mailed to about 1,000 churches, service clubs, varied women's organizations, and miscellaneous groups in Pinellas County announcing the availability of a speaker for a child abuse program. During the project, hundreds of such programs were presented involving all the PACER staff.

Probably the two hardest of such general audiences were most of the men's service clubs, who had fixed attitudes about child abusers and simplistic solutions (i.e., sterilization and severance of parental rights), and senior citizens groups who had unlimited time at meetings to discuss child abuse ad infinitum. During the project, child abuse programs were presented to a representative group of organizations in all geographical areas of the county. The one segment of the community from which there was not too much response for general child abuse programs was the black community, with the exception of a few black churches.

As a part of community public information about child abuse, a professional three panel child abuse exhibit was developed. This was used in shopping malls and health fairs. PACER staff manned the exhibit, answering questions, and asked people to take a "child abuse IQ quiz". This was a most effective way of looking at the general public's attitudes about child abuse, and frequently interesting discussions resulted in the shopping malls.

PACER purchased a wide variety of child abuse audiovisuals, which were used in professional training and educational programs. PACER was readily identified as the county agency with the most extensive and comprehensive collection of child abuse audiovisuals, and staff was recognized as being most knowledgeable and available for talks. Child abuse brochures were written, including relevant Pinellas County child abuse information and always distributed at professional training sessions and general child abuse programs.

In summary, it could be said that with the cooperation of the entire PACER staff, extensive child abuse training for professionals and public education was done during the project.

APPENDIX B

Parents Anonymous

PARENT AND CHILD EFFECTIVE RELATIONS (PACER)

Component: PARENTS ANONYMOUS

## I. Introduction

In the original grant for PACER it was proposed that chapters of Parents Anonymous be established within Pinellas County. The concepts used in establishing the groups would be those sanctioned by the National Office of Parents Anonymous and their guidelines would be followed. PACER began to develop the concept in November, 1974.

## II. Description of the Group

Parents Anonymous is a self-help group for parents who feel that they have the potential to abuse their children or who are actively abusing their children. Six forms of abuse are recognized: physical, emotional, verbal, and sexual abuse and physical and emotional neglect. Parents Anonymous takes the stand that no one form of abuse is any worse than another: all forms of abuse are damaging to the parent-child relationship.

The group has a chairperson - a parent with an abuse problem - who is responsible for conducting the meetings. A sponsor from the community attends the meetings to facilitate discussion and to provide resource information.

The meetings are held weekly and are two hours in length. During the week parents are encouraged to call each other with problems or crises in order to provide support for each other.

Therefore, the purpose of the group is two-fold: to provide weekly meetings during which parents exchange alternative methods of dealing with their children and their own feelings, and to offer some format for crisis intervention during the remainder of the week.

## III. Establishing a Chapter of Parents Anonymous

A. The first step in establishing a group was to obtain the name of one parent who would be interested in forming a group and who would be willing to take telephone calls of potential members and other inquiries. It was felt that a private party taking calls would tend to frighten fewer people away than would an agency telephone number. However, it was also felt that if such a person could not be located immediately, it would still be possible to utilize an agency telephone number with some degree of success.

In our case, the PACER Assistant Director did locate an interested parent who agreed to use her telephone number to take calls from parents who wanted more information or who were in crisis. Prior to this, consideration was given to linking up with the community-wide Information and Referral Service which operates on a twenty-four hour basis.

B. The second step in establishing the chapter was to find an appropriate meeting place. The Young Woman's Christian Association in St. Petersburg was selected because of its central location, availability of parking, meeting room facilities, and most importantly, a nursery.

Originally securing a church as a meeting place was avoided since it was thought that it might tend to evoke guilt or anxiety in potential Parents Anonymous members who might be scared off. However, The National Chapter of Parents Anonymous does not believe this to be valid. They feel parents are receptive toward the use of churches as meeting places since frequently they have good nursery facilities, although it must be made clear that Parents Anonymous is not church-affiliated.

C. A third step which was a necessity, was obtaining good babysitters or child care workers to care for the children during the meetings. In this instance, the YWCA already had a nursery service in operation for YWCA members attending evening meetings for 25¢ per child and was willing to make this service available to parents attending Parents Anonymous.

The availability of child care service was imperative since many parents would not be able to attend without it. It was fortunate to discover this ready-made arrangement since it was initially felt that it would be necessary to recruit volunteers from the local junior college human services program or from the teen volunteer program through the Red Cross.

Interestingly enough, at that time, the YWCA was planning to replace its paid babysitters with volunteers from the same resources and was interested in developing a more sophisticated educational program for children.

D. In order to "kick-off" the group, PACER Project invited Jo L., of the Parent Chapter of Parents Anonymous, to St. Petersburg in order to conduct publicity and to lead the first meeting. The first meeting date was set for December 5, 1974, on a Thursday night in coordination with the visit of Jo L.

Although the Parent Chapter of Parents Anonymous did have a grant through HEW to fund their travel expenses, they had already utilized that portion of the grant allotted for the Florida area. Therefore, PACER did have to cover the expense of the trip.

E. The publicity for Parents Anonymous was centered on Jo L., a a focal point. A volunteer in the community assisted the Assistant Director in making contacts with radio stations, television stations, and local newspapers.

Fortunately, St. Petersburg proved to be a community which was receptive and co-operative in dealing with social problems. Jo L., was scheduled on four television shows and three radio shows, plus coverage by local television news. Three interviews with feature writers of our three major newspapers were arranged. These were all scheduled within two days which meant an extremely tight schedule for Jo.L.

F. Besides the massive publicity regarding Jo L., contact was made with the local protective services agency (then called Division of Family Services) and other social service agencies in the community about three or four weeks prior to the first meeting, informing them about Parents Anonymous and trying to get referrals. These contacts were made in a written form with time, place, and the date of the first meeting together with a description of the group's purpose and goals. Other personal contacts were made with agencies via PACER staff.

IV. Formation of the Group

At the first meeting 18 people attended. Some, however, were referred under false pretences of going to a group for "frustrated parents", or to a child management class. Consequently, some of these parents were scared away after the first meeting when they were exposed to so many gut-level reactions and profanity from parents with extreme anxiety. The Project Director and the Assistant Director did begin serving as the group co-sponsors after the first meeting. At that time the role of sponsor did not appear to be well defined or very clear, so that they felt somewhat on their own in developing a proper role definition.

At the second and third meetings, six parents attended, which was a huge drop in attendance; however, the interaction was very productive, and the mutual problem solving began occuring. A genuine core-group seemed to begin development.

After the fourth meeting in January, a chairperson was selected by the group of parents who were attending. The Assistant Director of PACER, as sponsor of the group, did play a part in the selection of this particular parent as chairperson since she seemed to be very involved in the group process, was very articulate about her own abuse problem, and did seem to exhibit some leadership skills.

V. Development of the Group from January, 1975 to March, 1977.

Following the initial drop in attendance after the first meeting and the selection of a parent as a chairperson in January, the size of the group and regular attendance continued to fluctuate. In January one co-sponsor of the group met with the three parents most involved in the meetings to stimulate their planning in the activities and their role in maintaining the group. As a result, these parents, especially the chairperson, did plan several publicity efforts for television, radio, and the newspapers, which enhanced their involvement tremendously. At this point in their increased involvement, the Project Director withdrew as co-sponsor.

Throughout January and February more publicity conducted by these parents continued; however, the number of people attending the meetings remained rather constant, despite the television and radio programs. Though many inquiries were received from all parts of the county from parents and from agency personnel, the actual number of parents failed to alter significantly.

In March, 1975, the inquiries showed some increase seemingly because of two television shows; inquiries were made from Orlando, New Port Ritchey and Gainesville. By April, 1975, the group showed some signs of stabilizing and a truer group identity began to emerge.

In May, 1975, the group appeared to be well-cemented and approximately 8 to 10 parents were attending. Much support from the sponsor of the group was required. The process of the group interaction was becoming more refined and parents began to move beyond ventilating feelings primarily toward looking at their marriages, their childhood, and their feelings about themselves. This seemed to indicate a shift in the general function of the group which seemed primarily focused upon releasing frustration.

Throughout June and July, 1975, no new growth of the group occurred despite publicity; a fall-off of attendance occurred in August, 1975, which seemed related to vacation and summer time.

In September and October, 1975, some pick-up of group membership occurred which seemed related to the children having some difficulty with school, creating more frustration for parents. The group membership did increase somewhat to about eight parents.

In November and December, 1975, and January, 1976, the group remained at a status quo. Communiques were sent to community agencies to obtain referrals. The two week break at Christmas which occurred because the YWCA was closed did affect negatively the number of parents who continued with the group. Also in January, 1976, a visit was made with the sponsor of Parents

Anonymous in Tampa, a child psychiatrist, who expressed similar problems in maintaining his chapter.

In February, March and April, 1976, no significant change occurred within the group, the average attendance remained at about five. However, in May, 1976, three events occurred which seemed to alter the group to some degree: (1) the chairperson dropped out, (2) a television appearance by the sponsor on a 12 Noon television news program received numerous calls, and (3) new parents came forth seemingly as a result of professionals in the community who attended the PACER Child Abuse Seminar in March. The sponsor assumed total responsibility for running the meetings.

Throughout May, June and July, 1976, this growth - from about five people to nine or ten - was an improvement. In addition to parents attending the meetings appeared to be coming from a much more middle-class background. In reality an almost total turnover of the group members occurred (with one exception). The members themselves began interaction in a more therapeutic fashion, were experiencing rapid progress, and were making many gains.

The same type of positive interaction did occur throughout August, September and October, 1976, though again the membership declined to some extent in August, building back up in September. In October, 1976, Marriage and Family Counseling of the Juvenile Welfare Board agreed to assign a marriage counselor as a sponsor of the group in view of the forthcoming termination of the group.

In November and December, 1976, and in January, 1977, no significant changes occurred with the group, though membership dropped slightly. The former chairperson did return to the group but did not assume her former role. In January, a new counselor was assigned from Marriage and Family Counseling (different from the one originally appointed) and began attending the meetings in February and March, 1977.

During February and March, 1977, the sponsor of the group began withdrawing support from the group to some extent in an attempt to transfer her role to the new sponsor. The group membership decreased even more so that approximately three to five parents were attending. In March, 1977, the new sponsor requested that termination of the group occur, and this did occur on March 22nd, 1977, after two years and four months.

## VI. Group Process

Because of the unreliability of attendance of the group, turnover of members, and the various personalities, it was very difficult to move from ventilation of feelings to problem-solving with more in-depth problems that the parents were experiencing. Only during two periods of the group's development did this seem to occur. The group's greatest value, from this sponsor's point of view, rested with (1) therapeutic value of ventilating, (2) the acceptance of parent's negative feelings toward their children (the parentdid not feel he was

the only one experiencing these problems), (3) the number of successful referrals made to a host of agencies in the community, and (4) the socializing process that occurred between the parents (during the meetings and between meetings).

Initially, the sponsor viewed the goal of the group as an opportunity for parents to "exchange alternative methods of dealing with behaviors of their children. More often, than not, the parents who attended the meetings had great resistance to the behavioral alternatives suggested and were very inconsistent in implementing any of them. Some of the parents were already familiar with the various alternatives; other parents could not begin to relinquish the role as authoritarian. Many of the parents felt they were bribing their children if they praised their children for any positive behaviors. ("Why should I tell him he's good when he's only doing what he's supposed to?") Only a small percentage of parents seemed to be open at all to different forms of child discipline, despite the fact that many vocalized the opposite.

However, from the sponsor's view, there did exist great value for the parent in being able to verbalize the abuse occurring in the family and being able to face the fact that a problem existed in the home. Following the parent's process of getting this "off his chest", followed a period of more receptability to various treatment alternatives. A high percentage of parents were able to learn of other services and to seek them out. Very often parents had very unsatisfactory experiences in the past with problem-solving services and were able to work through their resistances in order to try again.

Consequently, the sponsor began to alter her goal somewhat so that services became a prime focus. For example, many parents had great feelings about using day care since they seemed to feel they were even more inadequate if they had to resort to using such a service. This issue arose rather frequently; however, it became clear to the sponsor that when the parent was able to be away from the child for some periods of time with some regularity, the quality of the parent-child relationship improved, while the frustration for the parent decreased.

In addition to day-care as a frequently suggested service, the following services were suggested by other parents or by the sponsor: Headstart, counseling, (at three different agencies), psychological testing, speech and hearing therapy, Over-eaters Anonymous, Children's Medical Services, Protective Services and placement, vocational training, child management classes, Parent Aides, Homehealth Aides and Homemaker Service, school psychological services and social workers, summer camps, and welfare services. From the sponsor's view, the referrals which the parents accepted were followed through by the parents with good results. The service suggestions seemed to have even more merit to the parent if the suggestion came from another parent who had experienced some success. (i.e. "That day care really works ... it's terrific!) It seems worth noting that in one instance, a very authoritarian rigid parent was the one who kept recommending behavior modification to other

parents though he could not use it himself.

In summary, it could be said that most parents were concerned whether the behavior their children were exhibiting was normal and were greatly relieved to find, in most instances, this was the case. Being able to view their children's behavior and their own feelings about is as more within the normal range was helpful and therepeutic for the parents. Many of the parents were able to begin to evaluate their own stress level and how they reacted to handling situations with their children as well as other various situations in their lives. This proved to be a big step and altered their behaviors to some degree since they were able to change their perspective of their problems.

The parents also benefitted from learning to "bail out" of situations, though in several situations the parents with more severe abuse problems did not have resources available to them to use to "bail-out". Some of the parents, consequently, began to turn to other group members for help with various degrees of success. Most parents did not have the capacity to handle the dependency needs of other parents.

## VII. Referral Sources of Parents

The majority of the parents were self-referrals who came as a result of publicity. Fewer than five parents were referred by Protective Services, one from a private physician, three from Parent Aides. The second largest source was from counseling services, such as Marriage and Family Counseling or Child and Family Comprehensive Mental Health Center; unfortunately, many of these parents were referred under false pretenses, (such as "it's a group for frustrated parents", or "a child management group"), and, therefore, dropped out after one or two meetings. One couple referred from a hospital following a very severe abusive incident attended voluntarily, but were later court-ordered to attend. Three other parents were court-ordered; one showed up for a few meetings and never returned. The other two never appeared.

## VIII. Techniques in the Group

During the initial period in which the chairperson was largely in charge of the meeting, the meetings were unstructured and the topics surrounded current problems with their children, "how the week went", problems from other sources causing stress etc. When the group became more cohesive, self-esteem problems marital and communication problems, and other areas such as depression, anxiety, etc., were able to be delved into. Unfortunately, the cohesiveness did not last for long periods o time.

Unfortunately, when new members arrived or dropped in for one meeting the sponsor and chairperson needed to focus upon that parent and his immediate need which disrupted the on-going group to some extent and became repetitive both to the sponsor and the chairperson, and to other group members, causing some breakdown of the group.

In May, 1976, when the chairperson dropped out of the group, the sponsor began to lead the group and used some different methods of evoking discussion, such as movies, tapes, film strips, various atricles, and role-playing. These were very useful and most parents related to them very well. This method did have value and could have been utilized with even more benefit with additional planning. The success of these seemed also related to the nature of the parent's problems, personality, verbal skills, and capacity for insight, in addition to the chairperson's learning.

IX. Out-Reach Activities

The sponsor was called upon by the nature of the group's make-up to do extensive out-reach. Approximately three to four telephone calls were received from parents each week, while the sponsor initiated many phone calls to improve parent attendance. The chairperson also made many phone calls to parents during the week; later one parent was placed in charge of calling parents each week to remind them of the meetings. Despite the number of hours on the telephone, the number of parents who attended did not increase significantly; however, it did seem to contribute to the group's stability.

Transportation was a major problem for several parents and contributed to some drop-out. The sponsor did provide transportation to one parent with regularity, and frequently transported the chairperson to meetings, to television and radio stations and to speaking engagements. With another family with severe abuse problems, the sponsor took the parent to meetings, stopped by during the week, and provided transportation for medical care.

The sponsor also spent innumerable hours providing emotional support to the chairperson who herself has frequent emergencies and crises. In essence the sponsor became a "parent-aide" to the chairperson.

Because of the dependent personalities of most of the parents several of them began calling the sponsor at work and at home desiring a similar relationship. Interestingly enough, they seemed to feel more free to call the sponsor rather than other parents with day-to-day problems because the sponsor appeared to them to be a "pillar of strength", while they felt the other parents in the group had their own problems to contend with. This lent itself to an extremely demanding, time-consuming role for the sponsor to play.

Both the sponsor and the chairperson took several calls involving parents in actual crisis with their children; though crisis intervention of sorts was provided to these parents via telephone, many of them never arrived at the meeting.

X. Child Care

Child care was essential for parents being able to attend meetings. Shortly after the meeting began the YWCA stopped providing professional child care for all parents attending evening meetings and began using volunteers. Later one volunteer began working exclusively with Parents Anonymous.

In this particular instance, the volunteer was outstanding. She was a student at the local Junior College, enrolled in their human services program. In January, 1976, a field placement was arranged for her and another student to be with PACER and to plan a more organized child care activity program geared to the needs of the abused child. Both students remained through June while the original volunteer remained until September, 1976.

The continuity of the child care program seemed to lend some stability to the Parents Anonymous group. The children were eager to participate and enjoyed the program so much that they seemed to encourage their own parents to attend the meetings. While several parents remarked about this factor and were pleased, they also said they felt more free to participate at the meetings since they did not have to worry about whether their children were receiving good care.

Both students were bright and very creative, developed relationships with the children, and made significant observations weekly about the children which assisted the sponsor in identifying problem areas on which to help the parents. On a few occasions, one student came to the meetings and discussed with the parents the development of their children. This was a very fruitful expenditure of time for the student, the parents and the sponsor.

In September, 1976, the services of a paid professional and volunteers from the local high school Exchangette Club were obtained. Despite a commitment from both to attend weekly, this has not always proven to be the most reliable arrangement, did not contribute to the group's continuity, and provided anxiety for the sponsor since their attendance was unpredictable.

XI. Role of the Chairperson

The role of the chairperson proved to be a very difficult one for the parent who accepted the position. Initially, this parent's self-esteem increased tremendously, her insights into herself were remarkable and her verbal skills were excellent. However, as the group continued she became more and more needfull to remain the center of attention. Her listening skills diminished and she seemed to feel jealous or cheated if she could not focus on her problems for a good portion of the meeting. Consequently, she needed the attention of the sponsor before the meetings, after them, and during the week.

At the meetings she began to interrupt other parents, make inappropriate comments, such as "That's nothing, you should hear what happened to me." Later, she seemed to begin to fabricate stories in order to enthrall the other group members. Then, too, her own dependency needs became so great that she began making demands on other parents for transportation, financial needs, etc., which contributed to parents discontinuing with the group.

In her role as leader, she then seemed to develop a need to view herself as "cured". Since she had participated in Parents Anonymous for so many months she seemed to feel that she should have mastered her problems. Consequently, she stopped using the group to deal with her problems. She began denying difficulties and started focusing on her own past. When she could no longer use the group therapeutically, she became more and more uncomfortable in her role and these feelings were transmitted to the other parents in the group. As a result of her inability to use the group therapeutically, her own relationship with her children began to deteriorate. On one occasion a PACER staff person did make a report to protective services regarding her care of the children. Though protective services did make a visit, they did not determine that a problem existed. On a second occasion the sponsor of the group did contact a social worker in regard to reoccurring probelms. This action precipitated the chairperson's withdrawing from the group for five months.

It must be noted, however, that this parent, despite the difficulties noted above, did devote hundreds of hours of personal time giving talks to professional groups, to community groups, appearing on television and taping radio programs, and learning a great deal of factual material about child abuse. These activities were, in the sponsor's estimation, more therapeutic to her in improving her own self-esteem than the group interaction itself. This parent did, in addition, perform a community service and deserves much credit for being able to discuss her problem so openly and in such an articulate manner. Though she did expose herself to some criticism, most people were impressed by her presentations, praised her for her openness, and did learn a great deal from her about child abuse.

## XII. Role of the Sponsor

It was assumed from the written materials received from the Parent Chapter of Parents Anonymous that only a parent with an abuse problem could initiate a Parents Anonymous group. If that parent, and a few other members decided a sponsor was needed, they would seek one out. However, it was later learned from Jo L., that this was not the case, but that in fact, chapters with professionals initiating and planning activities had a greater chance of success than those without professional assistance.

In this case, two co-sponsors, the Project Director and Assistant Project Director, assumed the role of group leaders until a parent could emerge from the chapter. The sponsor's role was comprised of helping the parent to stay on-topic, of helping the parent to express his or her feelings, and of being extremely supportive. Initially, both co-sponsors took an active role in the group; as the group cohesiveness began to emerge, their roles altered to some degree. In January, 1975, the Project Director withdrew as co-sponsor when a parent assumed the role of chairperson.

As the sponsor of the group, my role became one of nourishing the chairperson, helping her learn empathetic responses, and of teaching her dynamics of child abuse. It also entailed attempting to involve the parents in the group, providing emotional support for them during the week, and arranging massive publicity.

The role itself became filled with frustrations and demands, and much more time-consuming than originally imagined. It was hoped initially that the chairperson could assume more responsibility for running the meetings when she developed appropriate skills; however, this never actually materialized to the extent necessary for group operation. Consequently, the sponsor became increasingly involved in the operation and eventually assumed the role of group leader without a chairperson.

It was satisfying to some degree to actually experience parents opening up with gut-level feelings in a short length of time. (Coming from a protective services background, I found this openness extremely unique). It was also satisfying to see the positive changes occurring in individual chapter members, even though the changes were slow and setbacks happened. When parents who had been with the group were able to help in-coming new parents using suggestions and responses they had learned from the sponsor at the meetings, it was rewarding.

However, many of the parents had extremely high dependency needs which needed to be met and consequently turned to the sponsor for these satisfactions. As previously noted, the sponsor did become, in some senses, a "giant parent-aide", receiving numerous phone calls during the week, initiating calls, making referrals, or just chatting with parents. It became clear to the sponsor that despite the numerous hours spent in these contacts there was no guarantee that these same people would attend the meeting the following week.

Despite all the efforts made as a sponsor, I felt discouraged over the fluctuating membership. It was difficult to speculate about the success of the meetings. From the sponsor's perspective, a meeting might have appeared to be excellent: however, the next week the attendance would drop greatly; other times a meeting might appear to be unproductive; the following week attendance would increase. A parent might appear to enjoy a meeting, but never return, while another

parent who did not seem to be benefitting might return every week. This unpredictability and uncertainty was difficult to deal with on a week-to-week basis.

I would add that I feel that my personal interest in the parents, developing relationships with them, etc., played a great part in what success the group had. Some parents did follow through on referrals for services, and wanted to share their experience with me, thereby wanting to please me by their behaviors. It was rewarding to see some changes occur with a parent as a consequence of my relationship with them.

Needless to say, as a sponsor, I needed tremendous support from the PACER staff to maintain this role: I did spend many hours ventilating to other staff members about my frustrations. Without that opportunity, I would have never lasted in the role for the length of time that I did. Very minimal support came from the Parent Chapter of Parents Anonymous, and only when I initiated it. At one point, I considered starting a second group called "S.O.S." - Save Our Sponsor - to provide emotional support for those of us in this demanding and frustrating position.

My view of this role was confirmed by the fact that the sponsor for the up-county Clearwater chapter dropped out very rapidly and again the sponsor secured to replace me has already withdrawn.

XIII. Number of Parents Attending

During the two years and four months the group operated some 65 different parents came to the meetings. The parent serving as chairperson attended over 75 meetings.

Approximately 25 people attended one meeting or 39%.

About 9 parents attended two meetings, or 14%. Approximately 16 parents attended from three to six meetings, or 25%. Approximately 14 parents attended from six to twenty meetings, or 22%.

XIV. Portrait of the Parents

The parents represented a cross-section of race and included Caucasian, Black, Mexican, Japanese and Spanish. The majority of the parents were Caucasian working-class people, who seemed to be having some financial difficulty, but who were ineligible for welfare services or assistance. Most were two-parent families and included 14 couples who came to the meetings. Less than five indicated receiving welfare assistance. A cross-section of religions was represented; the majority were Protestant, while others represented the Catholic and Jewish faiths.

Significantly, most parents described their childhoods as unpleasant or as having been exposed to either emotional or physical abuse or both. Many had startlingly similar experiences as children and could be described as products of Helfer's WAR Cycle (World of Abnormal Rearing). Indeed, most were repeating the kinds of rearing patterns to which they had been exposed. Other characteristics which the parents generally exhibited in varying degrees were the loneliness and isolation, poor self-concept, unsupportive spouse relationship, depression, and unrealistic expectations for their children. The parents who were exhibiting some of the above characteristics in lesser degrees but also exhibited more strength in areas such as basic intelligence, level of education, and other supports or "bail-out" in their lives (i.e. husband, relatives, or friends), were able to use the group rapidly and well. They accepted new ideas, could utilize them in their lives, and could experience individual growth to overcome their abusive problems. Unfortunately, the parents who exhibited the characteristics listed above in greater degrees and who had fewer basic strengths had greater difficulty benefitting from the group.

XV. Types of Problems

The types of abuse that the parents frequently mentioned were physical abuse, emotional and verbal abuse, and emotional neglect. No parents ever presented the problem of physical neglect or sexual abuse to the group. Though the Parent Chapter of Parents Anonymous takes the stand that no one form of abuse is any worse than another since they are all damaging, most parents indicated that they thought emotional abuse was the worst. They all expressed the feeling that bruises to the baby could heal, while bruises to one's psychological well-being were more difficult to overcome.

The degree of abuse ranged from "screaming too much" to an incident in which the child was beaten with a board, nearly resulting in the child's death. It did not hold that a parent with a severe degree of abuse was helped more readily than one who had injured a child more severely. In actual fact, from the sponsor's point of view, the family who exhibited the greatest amount of change was also the family who had physically abused the child most severely. Their greatest changes seemed related to their basic strengths as opposed to their temporary loss of control which brought about the incident.

The majority of the parents who stayed with the group beyond five meetings had children under the age of eight; the parents who appeared most frustrated were those who had at least two children under pre-school age. Unfortunately, the group did not hold the same appeal for parents with teenagers who were experiencing different kinds of behavior problems. Only two parents with teenagers stayed with the group beyond five meetings.

Most parents were able to identify with problems of being unable to handle their anger with their children and needed help in learning impulse-control. This problem was one which the parents could commonly relate to and was the basis for many discussions.

The majority of the parents reflected behavior characteristics of neurosis and character disorders, as opposed to psychosis. Basically, many parents were functioning in a more normal fashion as opposed to a bizarre manner, but revealed immaturity, a lack of knowledge, and a lack of "bailing-out" know how.

Most parents were attempting to cope with problems normally faced by all parents, but viewed their problems in an exaggerated perspective. Many had poor impulse control coupled with limited knowledge of alternative behaviors.

XVI. Summary of Observations Regarding Parents Anonymous

1. Establishing and maintaining Parents Anonymous was an extremely time-consuming and difficult task to undertake. Parents Anonymous did not hold the appeal for abusive parents as was originally speculated that it would achieve, nor the kind of appeal usually described by the Parent Chapter of Parents Anonymous. The group is limited in the sense that it seems best suited for parents who recognize that they have an abusive problem. Despite a tremendous amount of time spent on publicity which was geared to problem identification; the group itself never became larger in number than ten.

2. The following were therapeutic benefits derived from Parents Anonymous which were received in various degrees by some of the parents attending the meetings:

(a) an acceptable place to ventilate frustration and anger
(b) an opportunity to be away from the children for two hours each week
(c) socialization with other parents
(d) an opportunity to learn alternative ways of coping with their children, their marriages, themselves, and with other stress in their lives.
(e) a means of recognizing their own feelings, particularly anger, and redirecting their feelings into more productive channels.
(f) an introduction to a range of social services available to them which would help in coping.
(g) a crisis intervention method of calling others for help and a process of learning that it is acceptable to seek help.

3. The actual amount of social interaction which occurred was less than anticipated by the sponsor. This interaction was hampered by the immaturity of some of the parents' personalities which led to unsatisfactory relationships between them. Some good solid social interaction did occur occasionally, but for the minority of parents, in attendance. At times minor arguements and disagreements did occur between parents which hampered group cohesiveness and contributed to a break-down of the group. Again, this seemed related to the immature personalities exhibited by the parents and the diverse personality make-up of the group.

4. Upon two occasions it was necessary to file reports of abuse and neglect. These reports were made because the parents were functioning at such a minimal level that the children were in danger. In the first instance, in spite of the fact that PACER was the reporting source, the protective services worker could identify no problem. In the second instance no protective services worker was assigned for six to eight weeks, even though the case was called in at the point of crisis. In the first instance, the parent knew someone connected with the PACER staff made the report. In the second instance, the parent was not aware. In neither circumstance did the parent discontinue contact with Parents Anonymous, but seemed to benefit therapeutically from the protective services report.

5. In three instances parents were court-ordered to attend Parents Anonymous. Only one couple was consistent in attending. One parent came to two meetings; another couple never arrived. However, the couple who did participate on a long-term basis as part of a court-order achieved a great amount o success and received a good deal of emotional support from Parents Anonymous. The sponsor provided them with encouragement, attended court-hearings with them, and testified in their behalf.

6. In one instance, a parent referred by Protective Services attended three meetings of Parents Anonymous, but never could participate fully in the discussions. She did say that she had a lot of bad feelings toward her two year old daughter. She later called to say she was moving to Tampa. It was learned, still later, that her two year old child had died and her two other children were hospitalized. Both she and her husband were arrested and placed in jail. Needless to sa the parents in the group, as well as the sponsor, experienced a great deal of guilt as a result of this incident.

7. Transportation was a tremendous problem for several parents and did contribute to the inconsistent and fluctuating attendance. The majority of the parents provided their own transportation; other parents needed to get rides from other members, from neighbors, or from the sponsor. Parents without cars posed a problem for members who had their own transportation since they needed rides every week, and were frequently requesting them. The parents with transportation soon became frustrated with assuming the responsibility of th more dependent members and (1) dropped out themselves, or (2)

refused to give rides. Only one parent without transportation was provided that from an outside agency. The sponsor did provide transportation to one parent regularly and to two other parents on several occasions.

8. The role of chairperson is a very difficult one to fulfill, especially for a parent who has the characteristics generally associated with the abusive parent. The role itself seems to contribute to a compelling feeling for the parent to be "cured", or to "close up". As a consequence, most parents who assume this role would probably find it to be problematic. It is also difficult for a parent to assume a role which requires knowledge of group dynamics, an ability for diagnosis, etc., which is gained through professional training. The demand of this role seems to add to the demands made upon the parent in his everyday life so that without caution used, the role might be too much of a burden for the parent to bear. While a parent does seem to experience an improvement in self-concept with this status, it may not be enough to counteract the strain which is imposed.

9. A real factor in the success of the group seemed to be whether the personalities of the parents meshed, or if they "hit it off". The parents did not necessarily have to experience indetical problems, but they seemed to have to identify with the other parents' problems. If the parents were to interact socially, it helped greatly if the parents had children of similar ages.

10. The role of the sponsor proved to be a demanding, exhausting one, if performed in the manner necessary to operate the group. It would seem unlikely that a professional would continue on a volunteer basis when one considers the amount of time and energy which is required.

## XVII. Termination of the Group

In October, 1976, Marriage and Family Counseling of the Juvenile Welfare Board offered to assume the responsibility for sponsoring Parents Anonymous. However, no sponsor ever materialized since the counselor assigned did not feel he had the necessary time. In January, 1977, a new counselor was hired and assigned to take over the group. He began at the end of January to attend the meetings.

On Thursday, March 17, 1977, Mr. Glenn and Mrs. Dame met with Mrs. Bennett to inform her they would not be continuing the group, that it would be terminated on Tuesday, March 22. The reasons he gave were the low attendance and the unreliability of attendance. Apparently, he also felt that the parents did not talk about the problems with their children enough.

Unfortunately, since he did not share his feelings with the sponsor prior to that date, or at the meeting, nor make any attempt to contact the sponsor prior to the final meeting, these factors were not explored to any extent. Also, it was too late to secure another sponsor to assume that role.



The group terminated on March 22, 1977.

XVIII. Recommendations for Parents Anonymous

1. New methods and means of obtaining referrals for Parents Anonymous should be explored with more emphasis upon referrals from Protective Services.

2. The group should be operated without a chairperson, but under the leadership of an energetic sponsor or co-sponsor who has strong agency support.

3. The sponsor should view the group as a unique concept in service; that it is not for the most past a traditional therapy group, but offers other benefits to families; those which have been described previously. The value of the group does not solely lie in discussing parent-child behavioral problems, but encompasses the total perspective of the family and its stress areas.

4. The value of providing an outreach service needs to be truly believed in and thus planned for. This holds true for the sponsor's initiating calls, accepting calls, and being available to parents.

5. Transportation needs to be planned for an in some cases arranged, if parents who really need help are going to obtain it.

6. Child care needs to be provided and isessential for group operation.

7. Court-ordered Parents Anonymous attendance should be encouraged and evaluated more closely.

8. Consideration could be given to the use of co-sponsors in order to ease the burden and to share the responsibility.

9. New methods of using educational materials could also be experimented with. The group, at various times, listened to the Helfer tape, Radl tapes, and viewed Child Abuse: Cradl of Violence, in addition to the Parent Magazine child develop ment materials. They appeared to learn a great deal and responded with much meaningful discussion. This appeared to be an effective technique.

10. Parents Anonymous is a needed service in the community which does offer benefits to families who attend. Though the number of families served has been limited it did reach a fairly substantial group of parents who do not ordinarily use helping agencies. It offered a kind of acceptance and out-reach to the family not ordinarily found in a traditional helping agency. However, for the group to be maintained takes a great deal of time, energy, dedication and commitment from the sponsor and from the community as a whole.

APPENDIX C

Parent Aides

## PARENT AIDE COMPONENT

### Development of Component

The component of Parent-Aides was developed according to University of Colorado Medical Center in Denver principles of lay-therapists. However, In Pinellas County, volunteers were recruited and screened, through TV and newspapers, by the program supervisor and then trained for 4 weeks, 2½ hours once a week. At the end of that time, families were approached by the caseworker to receive the volunteer. Matching was made on the basis of geographic locale, types of experience of volunteer to meet problems of client family, family composition and ages of children. Supervisor presented background of client family to parent aide who either agreed or suggested another type family. (one parent aide knew family he would work with; another disliked alcoholics, etc.)

Continuing supervision and weekly meetings are an essential part of any successful program using volunteers. The weekly meeting was held to assist volunteers to air their experiences and ventilate their frustration or elation at the relationship they they established.

Generally, the agencies which follow traditional counseling methods were skeptical of the use of volunteers and the dependence client family would have. Fears were expressed that parent aide would be "used" and ineffective because they would be "conned". Although this happened in some instances, the dependence was allowed in all cases and from that dependence came hidden strengths the client family did not realize it possessed.

The relationship of the parent aide and client family went through four stages:

(1) Acceptance of client family of volunteer because the idea sounded worthwhile

(2) Beginning of trust (about a 3 month period). Family begins to return calls, etc.

(3) Rejection of parent aide because client family expected rejection on part of volunteer. (Felt they told too much to parent aide).

(4) Once 3 overcome, client family experienced dependence on parent aide and much growth. Gradually, through tactful methods, dependence lessened and strengths began to show. Parenting imprint was given.

Throughout all stages, parent aide and supervisor worked closely together. Caseworker was also very much involved in comprehensive treatment plan.

Position of supervisor became one of co-ordinator because some families had been known to several agencies at once. Through staffings, coordination of a treatment plan satisfied all professionals involved and the volunteer became the catalyst in carrying out aims of plan.

Dear ends were reached when needs of caseworker superceded those of the family. (ex. families were not given help because caseworker refused supportive help to treatment plan). Probably found parent aide threatening. (This happened where parent aides were involved with a family who was later assigned a caseworker).

One of the problems met by the supervisor was the limited ability of some caseworkers to see what seemed so obvious in the client family problems. However, when the caseworker saw the whole program (volunteer plus supervisor) as supportive, much happened that was constructive. PACER was not the prime case management facilitator so ultimate decisions were made by caseworker of HRS. This facet necessitated a delicate balance which, when all concerned saw working well, brought constructive results. Other agencies brought into staffings gained insight into limitations of HRS staff, solely, meeting demands of family. In several instances, juvenile delinquency was prevented and the cycle of abuse broken. Families closed out by agencies have begun to function, trust and learn new skills of parenting.

The dead end reached by the program has been that the mandated agency can't pick up the program because of lack of funds for a supervisor's position. Volunteers need much support and encouragement, plus direction. They did not make major decisions, but conjointly with the supervisor arrived at a plan which could best benefit the family. Where the volunteer does not have access to the supervisor in time of emotional stress, he will quickly "burn out" emitionally and become ineffective. The supervisor's position is a full-time one.

Throughout the county, there are limited facilities to handle abusive families. Counselors who work in family agencies do not see themselves as capable of working with abusive families. They do not admit that they have such families in their caseloads, so they do not attack problems in this area. Many counselors are beginning to treat this whole area differently (due to the training and education component of PACER as well as the parent aide segment).

Project as a Whole

Most unique experience for me. I used every technique I have acquired in all my education and experience in both working with the volunteers and families and in the training and education area. There was much freedom to create and explore alternate methods of treatment and much momaraderie among the volunteers, caseworkers and me. The rewards came as the progress in families became more marked and the volunteers became more involved. As their expertise grew, so did their confidence. The agencies were receptive also when they saw the calibre people in the program. I was also allowed to make decisions and to approach other agencies directly. The program director gave each of us responsibility to develop the program for which we were accountable. This created a spirit of enthusiasm and high interest to present the best possible program. Working in this type of atmosphere gave each worker an incentive to develop to the fullest potential. The interchange at staff meetings each week helped relieve tension and sparked new ideas. Decisions were made conjointly with all of us giving pro and con aspects. Morale, all through the time we spent actively developing the components, was consistently high. It deteriorated after January when the reality struck that we were disbanding and four out of six had to look for new positions. The last few months have been filled with anxiety, panic, anger, frustration, depression and many mixed emotions about having done a "good" job with seemingly no results.

The most frustrating aspect of working in PACER has been, for me, little or no feedback on what I have done.

Only in the past few months, from about December on, has anyone in JWB indicated that the program was successful. On March 9, 1977, there was a volunteer recognition afternoon which provided the parent aides with accolades for doing so well. Agency representatives from Protective Services explained how the supportive aid did assist them and saved thousands of man hours. The director of HRS attended and his presence added to the dimension of the recognition for such dedicated people. He is still unable to provide a coordinator's position, but will do all he can to continue the program some way. One supervisor said she would like to absorb the existing parent aides, up county. This is a possibility of continuance.

Requests for the program have come from all over the country and Canada. On March 31, 1977, the parent aide coordinator will meet with Manatee Alliance for Youth Services in Bradenton, Florida, to see if the Manatee Comprehensive Mental Health Association and HRS may be able to provide a position and begin the program there. The Alliance is made up of various social, law enforcement, mental health agencies involved with families with child abuse and neglect problems.

Being within the JWB created a two-bladed Domocles' sword: one positive aspect: JWB funds most social agencies, so coordinator of parent aides was able to mobilize community assistance for families on strength of being based in JWB. Adversely, the same people were threatened by the fact that JWB could exercise power over them because of funding. This was a delicate balance, also, to keep, so role of co-ordinator became that of a facilitator for all concerned. Within the agency, PACER was a "step-child". Why, I am not sure, but since four out of six persons are being terminated, we have many unanswered questions on the use of Federal funds in demonstration programs. Not being in a position to elaborate, I will only point out that the parent aide component was successful and its termination is unfortunate for the families and children of Pinellas County.

APPENDIX D

Child Trauma Teams

PARENT AND CHILD EFFECTIVE RELATIONS (PACER)

Component: CHILD TRAUMA TEAM

I. Brief History of Team Development

In September, 1974, PACER's goal was to present a proposal for a multi-disciplinary team to be established at All Children's Hospital, which is the facility serving the largest number of children in the southern part of Pinellas County. It was hoped that a committee could be established to work out the detailed operations. It was planned that services of the Assistant Project Director be offered as team co-ordinator.

The proposal was presented to All Children's Hospital in October, 1974. In response to the proposal, attorneys at the hospital indicated that in their opinion the Florida Child Abuse Law did not cover physicians adequately and stated that they believed parental consent or a court-order would be needed before a case could be staffed.

To counteract their stand the Project Director wrote to Drs. ten Bensel and Newberger, as well as Mr. Brian Frazer, the attorney with the National Center for Prevention of Child Abuse and Neglect in order to get their responses and suggestions. They felt the Florida Law provided adequate protection for reporting physicians, but indicated that the possible resistance to the team was resulting from the fact that a group from outside their system was taking over.

In December, 1974, it was learned that Children's Medical Services were planning a program to deal with child abuse and neglect and could be of some assistance to PACER in establishing a team. However, by January, 1975, still no progress was made, although the material from the authorities in abuse and neglect had been sent to the hospital. The hospital, at that time, was encouraged to develop a team of their own without PACER involvement. Still no response was received.

In February, 1975, indirect word was received that Children's Medical Services were planning a team composed of physicians only. Coupled with no progress in March, PACER staff were quite discouraged with their attempts.

However, in April, 1975, Dr. Giffin, the Assistant Director of Children's Medical Services, reversed his stand in regard to the team and began developing a proposal for multi-disciplinary teams at All Children's Hospital and at Morton Plant, the up-county hospital serving a large number of Pinellas County children. His reversal seemed somewhat related to his contact with the Denver group from the National Center for Child Abuse and Neglect, who discussed at length the positive values of a multi-disciplinary approach to attacking the problem of child abuse and neglect.

In May, 1975, Dr. Giffin wrote a proposal and set a meeting for June in order to establish a committee to organize a team. The meeting held at All Children's Hospital was led by Dr. Giffin and attended by the hospital administrator, the hospital social worker, a selected staff pediatrician, an attorney ( new to the area of child abuse and neglect), a nurse and social worker from Children's Medical Services, the director and a phsychologist from Child and Family Comprehensive Mental Health Center, two staff from Health and Rehabilitative Services including the Supervisor of Casework Services and a line supervisor, in addition to the Director and Assistant Director of PACER.

The issue of confidentiality and legality loomed over the whole meeting with many fears being stirred up by two members of the committee. No resolution was derived, although the attorney was placed in charge of researching the legal aspects of the team and the Project Director was assigned to provide materials regarding alternative team models and letters which were obtained earlier. It was hoped that a team would be under way by September, 1975; however, PACER staff was not optimistic following the meeting.

In July, 1975, another meeting was held under the direction of Dr. Giffin who disregarded the past legal concerns of the committee and ignored some of the other presented difficulties and announced that a child trauma team would begin in September, 1975. The Assistant Director was assigned as co-ordinator and the PACER staff secretary was assigned to be team secretary. Other members of the team were a staff pediatrician, a psychologist, an attorney, and a supervisor from Protective Services. The hospital social worker and the social worker from Children's Medical Services were to be invited to the meetings. The team was given the rather innocuous title of The Family Consultation Team.

In order to avoid legal complications the team was considered to be a consultation committee to assist in "treatment planning" with Health and Rehabilitative Services. Thus, the team would be protected under the present Florida Law which allows for case discussion in relation to treatment planning and circumvents their otherwise strict rule of confidentiality. For the most part, the participants at the meeting felt adequately covered with this provision. Dr. Giffin must be given credit here for asserting his highly-thought-of position in the medic community in order to establish a team more rapidly than ever deemed possible by PACER staff.

In October, 1975, the first meeting of the Family Consultation Team was held. Some preliminary work done by the Assistant Director, such as a description of the team and its scope was presented. Much discussion occurred, along with revision. Another meeting was held in November to work out more details. This included adding the caseworker presenting case, replacing the assigned pediatrician with Dr. Giffin, changing psychologists and adding as "community resource" people, representatives from the Community Nursing Service (public health nurse) the school social worker, the Family Counseling Center, and

from the Adult Mental Health Center, who were to be called in on a case-by-case basis.

A delay occurred in receiving referrals from Health and Rehabilitative Services so that it was not until January, 1976, that two cases were actually staffed by the team. A meeting was held with the Assistant Director and the Protective Services Supervisor to resolve the fact that the supervisor felt there were no cases for the team. Again rumors were heard regarding the establishment of an up-county team.

Throughout February, March, and April, 1976, PACER staff was pleased by the kind of interaction the team was precipitating. Communication and service problems were being dealt with. Agency personnel were being forced to communicate and the beginning of coordination was occurring. The team received reinforcement from discovering recommendations were being carried out. Again the up-county team was showing more signs of development and planned to sit in on a team meeting. Impetus was provided by the March seminar which, again, emphasized the interdisciplinary approach for child abuse and neglect.

During May, June, and July, 1976, the team continued to function productively, although some attendance problems arose and getting appropriate cases to the team was again developing into a problem. Serious cases were discussed and good treatment plans were developed. Representation from the State Attorney's Office was added to the team and proved fruitful. Representatives from the up-county hospital attended the May meeting and held their own planning meeting in July, 1976 which was attended by the Director and Assistant Director of PACER.

During August, September and October, 1976, no significant changes occurred; however, it was beginning to be felt that the lack of cases for discussion was a matter of sabbotage as opposed to ignorance or a real lack of cases. At this point much enthusiasm was present and continuation seemed assured. Key representatives from various agencies were participating with regularity.

From November, 1976, through January, 1977, the situation remained stable. Plans were made for the social worker from Children's Medical Services to assume the coordinator's role held by the Assistant Director and a secretary was later obtained from the psychologist's office to replace the PACER staff secretary. At this point an evaluation of the team was held by team members with recommendations for (1) shorter and more organized case presentations; (2) more contact with the courts and judges in order to be officially recognized ; (3) more appropriate cases come to the team, especially hospital-based cases. (A clarification was needed since the interpretation of "hospital-based" was varied: our interpretation meant a case referred by the hospital; the child may or may not be hospitalized at the time of the referral or at the time of the staffing).

In regard to the up-county team, no change ever occurred following the planning meeting in July, 1976. The team was hospital-based in nature and required a staff pediatrician to bring a case to the team. According to that pediatrician, the hospital did not have any abuse cases to present. She said the few cases in the hospital were under the care of private physicians who did not want their cases staffed and who said they would obtain their own social services. Even though hospital staff were assigned to the team, no meetings ever materialized.

II. Skeletal Outline of Team

The team was community based in nature. All cases presented were reported cases and were brought to the team by Protecti Services. The standing members of the team consisted of:

(1) a pediatrician
(2) an attorney
(3) a psychologist
(4) a protective services supervisor
(5) a coordinator (from PACER)
(6) a secretary (from PACER)

Three additonal members were added:

(7) a hospital social worker
(8) a social worker from Children's Medical Services (state funded special medical programs)
(9) an attorney from the State Attorney's Office (responsib for filing dependency affidavits in contested cases).

Four additional key community people serve on a consultant basis to the team and are called in on individual cases prior to their staffing. The representatives were:

(1) the school social work supervisor
(2) a public health nurse
(3) a social worker from Adult Mental Health Clinic
(4) a social worker from Family Counseling Center

In terms of the actual team operation, discussion of each case presented was limited to twenty to thirty minytes wit summary of team recommendations consisting of medical, psychological, social and legal areas. Each case was sche for review in one or two months. The PACER secretary took minutes at each meeting of the discussion and recommendati Copies were mailed to all members and consultants. No na of families were included in the minutes.

III. Problem Areas Addressed

The team focused its efforts on the following:

(a) the physically abused child
(b) the medically neglected child
(c) the nutritionally neglected child
(d) the sexually abused child (limited to parents, guard or custodians).

IV. Referrals to the Team

(a) Agencies, hospitals, clinics, etc., desiring consultation by the team would report the case to Health and Rehabilitative Services.

(b) Health and Rehabilitative Services would be responsible for registering the report with state central registry, for gathering family history, other information, and for obtaining medical consultation regarding the diagnosis of child abuse.

(c) Health and Rehabilitative Services would contact the team coordinator to schedule discussion of the case with the Family Consultation Team.

V. Functions as Defined by the Team

The functions of the team included the following:

(a) To make medical, social and psychological recommendation for treatment planning.

(b) To utilize other consultants and resources from the community in the treatment plan.

(c) To hold at regular intervals follow-up conferences for each case discussed in order to review follow-up with the family and the recommended treatment plan.

VI. Legal Aspects of the Team

It was finally agreed that the Family Consultation Team would serve as a consultative committee to Social and Economic Services of the State of Florida (Protective Service thus, sharing information became a method of reporting to Protective services and, therefore, community agencies and organizations were protected from liability under the Florida Child Abuse and Neglect Reporting Statute. In addition, the section of the law dealing with treatment planning indicated that information could be shared when the goal was to derive a common plan; thus circumventing somewhat the strict rule of confidentiality.

Other legal aspects of team operation included the following

(a) All confidentiality would be stringently maintained. Treatment recommendations would be kept by the individual team members.

(b) Stress would be made on the legal rights of both patient and family.

VII. Development of Forms

During the development of the team two forms were created for its use. The first was a format for case presentation which

gave a summary of the necessary, or at least helpful, information in presenting a case. These included Dr. Ray Helfer's criteria which he uses to identify high-risk families and families with abuse problems.

A second form was a summary of team recommendations which was completed for each case and listed specific suggestions for each case being addressed. It also established a review date for each case.

VIII. Other Areas Covered by the Team

These were problem areas and goals the Team felt were within their realm:

(a) To establish a "local reporting mechanism" (central medical registry), if legally and financially possible, in order to increase detection and reporting.

(b) To consider consulting with legislative delegations when the laws do not appear to adequately cover child protection.

(c) To educate and encourage medical and health professionals to report child abuse.

(d) To encourage Juvenile Court to order evaluations be conducted by the team; to have the team officially recognized by the court and their recommendations admitte as court evidence.

(e) To allow for community professionals working in the field of child abuse and neglect to contact team members between meetings for consultation.

IX. Evaluation of the Family Consultation Team

A. Over-all View

The values of the team were numerous; it created an opportunity for coordination of services, for increased communication between agencies; and for a mechanism of education regarding child abuse and neglect, of learning new resources and services within the community. Proble between agencies could be "hashed out" and procedures were clarified. The review of cases provided feedback to the team members, encouraged consistency in case planning and use of services, and made agencies more accountable for their services.

B. Referral Procedures

The biggest problem was obtaining appropriate cases for staffing. Because the team was limited to staffing case presented through Health and Rehabilitative Services, a blockage occurred in the types and numbers of referrals which were came to the team's attention. At first, the

coordinator assumed that lack of experience on the part of the HRS representative was the problem. (i.e; In one conversation, the coordinator was informed that no cases were available for the team because "all of our problems are solved.") As this problem persisted to such a degree it became more apparent that the agency legally responsible for handling child abuse and neglect seemed fearful of opening up their agency to criticism, or "hanging out their dirty laundry", so to speak. Several of the cases were ones which did not require much treatment planning at that point in time, or were cases which were so difficult in nature that they did not lend themselves to much creative planning. (i.e; a psychotic retarded mother who was untreatable.) At other times their personnel failed to bring any case.

Fortunately for the team, one outstanding caseworker in protective services felt that bringing cases to the team was quite constructive. Since she was handling a few severe abuse cases, the team did have the opportunity to plan for these particular cases and did obtain excellent feedback from this caseworker and other professionals involved in these cases.

The coordinator did attempt to inititate some efforts to get more appropriate referrals to the team through contact with the hsopital social worker or protective services after she received information regarding a particular case from a variety of sources. Of course, this was a piece-meal effort and was only spasmodically successful.

Numerous efforts were made through PACER's Education and Training Coordinator to educate the community regarding the team amd its use, with a particular emphasis on protective service caseworkers. It was hoped that individual workers would begin to see the value of bringing a team for staffing. It was interesting to note that the majority of the HRS caseworkers who were present at her training sessions held in October, November, and December 1976, were unaware of the team's existence.

In December, 1976, the outstanding HRS caseworker who had exhibited a strong interest in the team was promoted to Protective Services Specialist and is continuing team participation in that role. She has been making a concerted effort to promote the team's value throughout her agency. Unfortunately, the representative from HRS who still maintains responsibility for the actual selection of cases to be presented seems to be operating in the continued manner of inappropriately selecting cases. This appears to be one of the largest stumbling blocks the team has yet to overcome.

Another factor in getting referrals from the caseworkers is again related to their viewing the team as a threat, rather than a helping tool in treatment planning. Their feelings may be related to the current view held by HRS personnel on the team, but also coupled with their own personal insecurities and lack of training from Health and Rehabilitative Services.

C. Development of Team Interaction

As time passed, the actual presentations of cases and discussions became gradually more organized and the recommendations improved. However, it has still been difficult for the coordinator to keep discussion limited to the specified amount of time. Most definitely, the member of the team with the greatest clout is the pediatrician. It is fortunate that he has taken forceful stands regarding the actual diagnosis of child abuse and has been willing to speak out. His opinions have had a great influence upon all persons attending the meetings and hold the greatest weight. His presence and participation have been a key factor in team development and growth.

As time has passed, members of the team and community representatives have developed more trust in each other and a certain camaraderie. The spirit has helped cohesiveness develop. Most people involved in the team have seen it as a very positive tool and have developed some pride in it.

Another key individual who contributed greatly to the team was the representative from the State Attorney's office. She was extremely knowledgeable in Florida law regarding child abuse and neglect and her participation enhanced the team greatly. Unfortunately, their office has dispensed with representation because they state it is a conflict of interest since they are legally involved with some of the cases presented to the team. From the coordinator's point of view, this is a superficial reason; the actual reason being that a great amount of dissention exists between Health and Rehabilitative Services and their office.

Certainly, a growth of knowledge regarding the dynamics of child abuse and neglect from nearly all team members has been demonstrated, and is reflected in the quality of recommendations.

D. Role of the Coordinator

The role of the coordinator was not an easy role, though it was interesting. Theoretically, the HRS representative was supposed to make contact regarding the scheduling of cases each month. In reality, during the year of operation, their representative initiated only one telephone call, again reflecting the existing resistance. Although an effort was made on the coordinator's part to maintain a somewhat objective view of the discussion, summarizing

when appropriate, and controlling the length of discussion, it was utterly impossible to be totally objective. Of course, this personal reaction probably came across in some instances, although the coordinator was aware of it and tried to control it.

It became apparent that some participants in the meetings saw the role of coordinator as a judge of their work or expressed a need for her approval of their plans. Certainly, the coordinator discouraged this as much as possible, but it did seem inherent in the role.

The coordinator needed to be well-versed in child abuse and neglect to perform the role well, since often problem areas in a family were multitudinous and needed to be defined more clearly before a good plan was developed. Also, the coordinator needed to have a working knowledge of community resources and contact people.

It was part of the coordinator's position to call upon "community representatives" on a case-by-case basis to attend meetings. Since the coordinator was almost never informed about which case was to be presented, she was unable to make the appropriate contacts prior to the meetings. If, when the HRS personnel were directly asked which community representatives would be present, they responded only once or twice. As coordinator, it was easier to make these contacts when case reviews were scheduled although not as effective.

It should be pointed out that the coordinator's role is one which has some power attached in that the coordinator is responsible for summarizing the recommendations and sending them out. Thus, the coordinator has the responsibility for making the final interpretation of what is to be accomplished in a written statement. This is a significantly important function.

E. Case Reviews

In perspective, this was the weakest part of the coordinator's position. Although the coordinator could request a case be reviewed or sent appropriate notices, there was no guarantee that people would be accountable or had carried out the recommendations. Consequently, in some instances in which the coordinator had first-hand knowledge that appropriate actions had not been taken, she did not call for the review since she felt that it would reflect on the team as a review board or a supreme court, and would only increase resistance to the team. At this point in the team's growth it appeared to the coordinator that staffing a new case would be more constructive. In the future, recommendation should be to routinely review each case which would be maintained in a rotating file.

In regard to case reviews, those made to the team were for the most part positive ones, thus reinforcing the team and the caseworkers involved. This feedback did provide enthusiasm and impetus to the team's operation and did enhance more coordinated community services. Some of the additions and revisions made at the reviews reflected increased awareness and knowledge.

X. Continuation of the Team Under Children's Medical Services

In February, 1977, the social worker from Children's Medical Services became coordinator of the team. Prior to her first team meeting the PACER Assistant Director and the Protective Services specialist met with her to clarify her role and to attempt to deal with some of the problems which had been identified. The Protective Services specialist had met with th Juvenile Court judges to inform tham about the team and had felt it was a relatively successful contact - they were receptive to her approach.

The first meeting which was coordinated by the new coordinator seemed very successful. The first case which was presented was an appropriate one and had been brought to the team with help from the PACER Assistant Director. The second case came to the team's attention via Dr. Giffin and was from a pediatrician. Both were excellent cases and the coordinator brought together an excellent array of professionals for the discussion. It was still apparent, however, the HRS representative was resistant to the kinds of recommendations being suggested and, in the absence of the State Attorney, seemed to make an attempt to practice law without a license in order to explain why the recommendations could not be carried out. Despite that, the meeting was a success.

The March meeting was much less of a success. Out of the ten persons present to discuss the case, seven were from Health and Rehabilitative Services. The caseworker presenting the case was very defensive and insecure. The case in question was controversial and was a mutual case with Children's Medical Services. Consequently, the coordinator had to wear the proverbial two hats and attempt to represent Children's Medical Services, as well as coordinate the meeting. This conflict in roles was extremely detrimental to the discussion. To complicate matters, neither the pediatrician or the psychologist were present which detracted greatly from the value of the team's recommendations and its status. The second case presented was a totally inappropriate one brought to the team's attention by the HRS representative. The caseworker, although well-meaning, did not have any information to present and most people asked her why she brought the case to the team. No recommendations could be made.

XI. Summary of Observations Regarding the Team's Continuation

1. It was difficult for the coordinator to represent an agency and conduct a meeting with the inherent role confusion. The current coordinator has an excellent understanding of the role and has leadership abilities; despite this, she will be faced with this serious problem.

2. It is essential that all key team members be present if the meeting is to be a success, especially the pediatrician. Protective Services caseworkers are, for the most part, not going to listen to other HRS personnel about how to do their job.

3. The method of receiving referrals will have to be altered in order to remove the power of determining which cases will be reviewed from this HRS representative. In the opinion of the Assistant Director, the HRS team representative (both present and former) has not performed adequately, either through competence or through an active effort to sabbotage team functioning.

4. Special credit must be given to the current Protective Service specialist who has contributed greatly to the team's success. Perhaps her role with the team should be expanded to assist HRS with the team and eventually becoming their official representative.

5. Without the aforementioned changes occurring the future of the team is not bright. It remains to be seen if key community personnel outside the HRS system will be able to exert enough influence to keep the team operational.

XII. Comments Regarding the Up-County Child Trauma Team

The hospital-based child trauma team at Morton Plant Hospital was established in name only in July, 1976. It has never held a meeting and does not appear to be nearing a meeting date. The problem appears to relate to the fact that a pediatrician is responsible for referrals getting to the team and for calling the meeting. Obviously, this responsibility was ill-placed.

It was unfortunate that PACER could not have played a more active role in establishing the team, but PACER's coming from an extra-system approach made this nearly impossible.

XIII. Appendix of Forms

(1) Original Proposal for Child Trauma Team

(2) Description of Family Consultation Team

(3) Format for Case Presentation

(4) Family Consultation Team Summary of Recommendations

(5) Sample Team Recommendations

## CHILD TRAUMA TEAM PROPOSAL

### A. RATIONALE

Child Trauma Teams are springing up across the country under various names. Those involved feel very positive about them and believe that they have the following advantages:

1. Bring an interdisciplinary approach to diagnosis and treatment planning which is otherwise difficult to achieve;

2. Provide a better communication method for the varied persons who become involved in case planning;

3. Relieve protective service workers from the burden of unilateral decision making in what sometimes are life and death decisions and which often must be made without complete information from all available resources;

4. Allow physicians to play a larger role in total treatment planning and to have more access to follow-up information;

5. Help parents to comprehend the seriousness of the process in which they are involved;

6. Serve as an educational experience for those involved and for auxiliary personnel who might not otherwise have an opportunity to gain in depth knowledge of child abuse and neglect;

7. Serve as a stimulus for the development of parent supportive services, training activities, and research.

One of the program areas contained in the PACER project is a child trauma team or teams. In considering where to begin in Pinellas County, one characteristic appears to simplify the process somewhat, and that is the fact that the county contains a progressive children's hospital which handles the majority of child abuse cases requiring hospital admission. Some personnel in the hospital have already given some thought to the establishment of a team. On this we predicate the content of this proposal.

### B. RECOMMENDATION

That All Children's Hospital be asked to consider implementing a Child Trauma Team as soon as details can be worked out. That any other hospitals which can be identified as having significant child abuse population be later approached about the possibility of team development after the program has been experimented with and refined at All Children's. Mr. Dennis Sexton of All Children's has been consulted and has made the suggestion that such proposal be presented to him for consideration by his staff.

(continued)

C. METHODOLOGY

If All Children's elects to attempt a team, it would seem appropriate to schedule some work sessions involving hospital representatives, a representative from the Division of Family Services, someone from the PACER staff, andsomeone with a broad knowledge of treatment resources in the community. They could detail the procedures for team operation and determine who would serve on the team both as nuclear members and elective members.

D. SUGGESTIONS

The following represents only ideas about possible team operation. As such, they are not meant to be a final proposal, but a beginning point of discussion from which could hopefully evolve a team that would be appropriate for this community.

1. Team Composition

The nucleus of the team might consist of:

(a) Co-ordinator - preferably someone with good working knowledge of all team members roles (including their organization's procedures, legal responsibilities, limitations, etc.), and someone who might have time to periodically gather information about case progress in order to provide the team with up-date reports and help them evaluate past team decisions. A PACER staff member, nurse, or hospital social worker might best serve this purpose.

(b) Pediatrician - one who is likely to, by virtue of his position, have knowledge of most cases that would be staffed by the team.

(c) Protective Services Worker - someone who could routinely commit the agency to a probable course of action in any given case. Might be difficult to work out depending on type of work distribution at agency, intake procedures, etc.

(d) Psychiatrist - this would not be a necessity but would be of help if one could be secured who has in-depth knowledge of dynamics of child abuse.

(e) Nurse - someone whose position at the hospital would enable her to see that the team receives information about observed parent/child interaction in the hospital.

(f) Hospital Social Worker - not essential but could be helpful in that such a person is often in a more ideal position than anyone else for securing an early interview with parents and setting proper atmosphere for referral to DFS, possible introduction of treatment resource people, etc.

(continued)

Elective team members would be those who are needed on some cases but not all. They might include:

(a) Radiologist

(b) Orthopedist

(c) Law Enforcement Person

(d) Neurosurgeon

(e) Public Health Nurse (might also be considered as nuclear team member

(f) Treatment personnel from various agencies

(g) Representation from legal community

(h) Psychologist

(i) Representative from agency who already has knowledge of family or therapist who already has family in treatment.

(j) Parents, in rare instances.

(k) Others as indicated.

2. Team Operation

(a) The role of each member would have to be determined as team composition is finalized.

(b) Procedures for easy referral of case to team would have to be arranged so that a variety of persons could make referral.

(c) Some method of recording team deliberation would need to be established.

(d) A specific day and time convenient to all should be set. An on-call basis would be preferable, but difficult to work out. Possibly, a regular schedule such as once a week or every two weeks would be an acceptable alternative.

(e) Case presentations might be arranged with brief observation and comment time for all members followed by discussion guided by co-ordinator toward decision making.

(f) A method for review of cases should be allowed for whereby any team member could request review if they feel the original plan has become unsuitable or circumstances of the case have drastically altered.

(continued)

(continuation sheet 3.)

3. Team Objective

The goal of the team's case effort would be to arrive at a total diagnosis and an acceptable intervention plan with specific duties spelled out for all pertinent team members.

TO: Family Consultation Team October 1st, 1975.

Re: Summary of the Description and Operation of the Family Consultation Team

As a result of the Child Abuse Committee Meeting chaired by Dr. Allyn Giffin on July 25th, 1975, it was agreed that a committee for the abused child be implemented.

1. The committee, called the Family Consultation Team, to act in an advisory capacity to Division of Family Services was formed.

2. The team would consist of Dr. Boyd Mullholand, pediatrician; Julie Christian, Division of Family Services Supervisor; Molly Alcott, psychologist; Barry Wax, attorney; and Carol Nosen, coordinator.

3. A secretary from the PACER Project would be designated, but not a Team member.

4. Consultants and other resource persons in the community would be attending specific team meetings as indicated by the Team. These community organizations should be contacted so that key members could be assigned as consultants. Alan Porter, Social Worker at All Children's Hospital; and Cheryl Moore, Children's Medical Services, will represent their respective organizations and will be notified of team meetings, dates. Other specific agencies who will be contacted for consultants are the Public Health Department, Adult Mental Health of Pinellas County, Family Counseling Center and the school social workers with the Pinellas County Schools.

5. The committee would at first limit its areas to these definable problems:

   (a) the physically abused child
   (b) the medically neglected child
   (c) the nutritionally neglected child
   (d) the sexually abused child ( limited to parents, guardians or custodians).

6. Referrals to the Family Consultation Team:

   (a) Agencies, hospitals, clinics, etc., desiring consultation by the team would report the case to DFS.

   (b) DFS would be responsible for registering the report with state central registry, for gathering family history, other information, and for obtaining mdeical consultation regardin the diagnosis of child abuse.

   (c) DFS would contact the Team coordinator to schedule discussio of the case with the Family Consultation Team.



(continued)

(continuation sheet 1.)

7. Function of the Family Consultation Team:

   (a) to make medical, social, and psychological recommendations for treatment planning.

   (b) to utilize other consultants and resources from the community in the treatment plan.

   (c) to hold at regular intervals follow up conferences for each case discussed in order to review follow-up with the family and the recommended treatment plan.

8. Legal aspects of Team operation:

   (a) All confidentiality would be stringently maintained. The Team members would keep individual notes; no Team "files" as such would be made. Treatment recommendations would be kept by the individual Team members.

   (b) Stress would be made on the legal rights of both patient and family.

9. Other points discussed:

   (a) To establish a "local reporting mechanism" (central medical registry), if legally and financially possible, in order to increase detection and reporting.

   (b) To consider consulting with legislative delegation when the laws do not appear to adequately cover child protection.

   (c) To educate and encourage medical and health professionals to report child abuse.

## FAMILY CONSULTATION TEAM

### Format for Case Presentation

I. Nature of Initial Report/Complaint by Social and Economic Services (Presented by SES).

1. Type of abuse or neglect (physical or sexual abuse; medical or nutritional neglect).

2. Date of report; source of referral.

II. Detailed hisotry of injury (ies) as described by mother/father/or by caretaker. (Presented by SES and/or hodpital social worker).

1. Include dates and tines

2. Who brought child to hospital (if applicable)

III. Social Information and Family History (Presented by SES and/or hospital social worker).

1. Age of parents, age of other children, sex, race, economic status, living arrangement. If school age, list school.

2. Past history of suspected or confirmed abuse or neglect.

3. Stress factors present in family (marital conflict, unemployment, social or health problems, other major crises).

4. Emotional stability of parent(s).

(a) Low self-esteem and/or depression

(b) Parents abused as children

(c) Inability to nurture child, or to provide case and supervision; lack of basic child care knowledge.

(d) Presence of alcoholism/drug addiction, or other problematic life-style.

(e) Result of any formal testing

5. Social isolation factors in family.

(a) Does the family have relatives or friends to turn to?

(b) Does the family use problem solving agencies? What agencies are involved at the present? In the past?

6. Child Factors

(a) Is this a "special" child? (handicapped, retarded, hyperactive, premature, or seen differently of "bad" by parents).

(b) Does the child have problematic behaviors such as colic, feeding problems, school-related difficulties?

(c) Parents' expectations for child unrealistically high.

(d) Results of formal testing.

IV. Presentation of Available Medical Information (presented by SES, hospital social worker or other health professional).

1. Hospital records
2. X-rays
3. Physical examinations
4. Examining physician's notes and/or consultations
5. Copy of emergency room record
6. Nursing notes
7. Lab Work
8. Other

V. Current Case Status (Presented by SES)

1. Whereabouts of child(ren) in question
2. What parents have been told regarding the incident of child abuse or neglect and their reactions.
3. Present legal status
4. Parental willingness to cooperate
5. Other agencies involved at present.

VI. Team Recommendations for Treatment

Plan and Follow-up

1. Medical (Presented by Team pediatrician)
2. Social/psychological (presented by Team psychologist)
3. Legal (presented by Team attorney)
4. Other Community Consultant Recommendations

FAMILY CONSULTATION TEAM SUMMARY OF RECOMMENDATIONS

Family Name _____

Name of Child _____ Birthdate: _____

Date: _____

Medical:

Psychological/Social:

Legal:

Other:

Date Scheduled for Review: _____

Date: March 23rd, 1976. Case #4.

Family Consultation Team Recommendations

Discussed by: J. Christian, B. Wax, Dr. Crum, A. Porter, S. Dillard, R. Manuel, N. Grybauskas, C. Moore, C. Nofen. Secretary: N. Conitz

Presenting Problem : Failure to Thrive

This three-month old premature infant boy was referred to Social and Economic Services from the Cardiac Clinic at Children's Medical Services because of child's failure to achieve proper weight gain. The clinic physicians question mother's ability to feed and to nurture the child and requested a home investigation with consideration of foster placement.

Social Information and Family History

This five-pound infant is the only child in aBlack one-parent low-income family. Two or three children have previously been removed from the home.

Mother appears to be in her mid-thirties with a history of mental retardation, alcoholism, seizures, and family instability. She is described as cooperative and pleasant, but exhibits great difficulty in understanding or following suggestions or recommendations for child care. Her severe mental limitations, in addition to an apparent loss of memory (attributed to a bullet lodged in her brain), contribute greatly to her confusion and to she herself being a victim of exploitation.

Per S. Dillard, Social and Economic Intake Social Worker, the home conditions and environment are satisfactory and an adequate supply of food was available for the baby when she visited the home. The alleged father of this child was present and seems to maintain family contact.

Medical Information

This infant has been seen by Drs. Bradsky and Cimino at the Cardiac Clinic of Children's Medical Services on a regular basis since the baby's cardiac surgery following birth. Dr. Cimino is extremely concerned about the child's failure to gain weight and has written a statement to that effect, indicating that the baby's medical problems do not appear to be contributing to this problem, and suggesting a thorough investigation.

Current Case Status

This infant resides at home in the custody of his mother. No legal action is pending. Mother verbally expresses a willingness to cooperate with the SES caseworker, Mrs. Manuel, who received the case in transfer from S. Dillard. The child continues to attend the CMS cardiac clinic.

## FAMILY CONSULTATION TEAM SUMMARY OF RECOMMENDATIONS

Family Name #4

Name of Child Infant Boy Birthdate: age 3 months

Date: March 23rd, 1976.

Medical: Recommend that the baby be hospitalized to determine the cause of its failure to gain weight. Continue medical service through weekly visists to Cardiac Clinic at C.M.S.

Psychological/Social: (1) Obtain a home health aide through Family Counseling Service (Nola Aalberts) for family to visit on a regular basis to teach child-care skills. (Mrs. Manuel agreed to make contact). (2) Obtain services of the public health nurse through Pinellas County Health Department. (A. Porter agreed to contact Janet Townsend, team consultant). Both servic to be utilized pending child's return to own home following hospitaliza tion period.

Legal: No legal recommendations at this time.

Other: Though mother seems cooperative and well-intentioned, serious question exists regardi mother's ability and capacity to utilize supportive services because of extreme intel lectual limitations, and health problems. Close supervision will be required by all agencies involved to monitor the baby's weight gain in order to insure baby's survival

Date Scheduled for Review: April 20th, 1976.

APPENDIX E

New Parent Information Service

## Introduction

In the original grant proposal for the PACER Project (Parent and Child Effective Relations) submitted to the Department of Health, Education and Welfare by the Juvenile Welfare Board of Pinellas County, recommendation was made for the development of a program to provide for early detection of parents-at-risk in the maternity wards of local hospitals. The original proposal recommended interviewing all parents of new borns within the county. Since the number of births averages 6,000 a year, this suggestion did not seem feasible nor operational. It was felt that a more realistic plan would be designing a model program which would operate on the maternity ward of one hospital.

## Development of Maternity Ward Monitoring

This program, entitled Maternity Ward Monitoring, was designed to focus on identifying parents-at-risk, or namely, those parents who fail to experience the "claiming process" with their babies. These parents are those who have difficulty with the attachment process which is a major factor in the development of a healthy parent-child relationship and which leads to a nurturing protective parenthood. When a parent does not understand his baby's emotional states nor identifies any positive attributes within the child, a high probability exists that the child is at-risk.

## Proposed Methods of Implementation

The program was designed to operate on the maternity ward of a local hospital where a registered nurse, or a trained volunteer, would make a series of systematic observations of parents with their new borns. The nurse or volunteer would observe parent-infant interaction and would attempt to detect behaviors that would be indicative of attachment problems.

A parent-child interaction check-list was designed to be utilized as a tool for observation. The nurse or volunteer would not interact verbally with the parent, but would be recording verbal and non-verbal parental responses only.

Those parents who demonstrated a high number of behaviors on the check-list indicative of a high probability of child-rearing problems would be seen by the registered nurse.

All parents of new borns would receive brochures or pamphlets indicating possible problems which might arise and the kinds of services available which they might utilize.

Proposed staffing included hiring a part-time registered nurse with use of federal funds. The duties of the nurse would include observations, completion of the check-list and follow-up home visits with parents-at-risk.

## Resistance to Maternity Ward Monitoring

The Project Director and Assistant Project Director met with various medical and health staff at Bayfront, Morton Plant and St. Anthony's Hospitals in order to attempt to implement the program. It became more and more evident that working from outisde the established system was to our distinct disadvantage. Though nursing staff and pediatric staff were enthu-

siastic, the obstetricians were very hesitant about such an approach. They were protective of their patients and wanted to determine which patients would be observed or would receive visits.

Some nurses were very encouraging about such a program since they felt that the proposed observations were similar to their nursing notes they already made on maternity patients. They quickly identified the high-risk observations; many nurses from time to time expressed concerns about patients who left the hospital with their babies and wondered how these parents cared for their new babies after leaving the hospital. Many expressed enthusiasm for a program which would provide follow-up services for families.

Unfortunately, despite the receptiveness of some professionals to maternity ward monitoring, the disapproval of the obstetricians was enough to stop implementation of the program.

Revised Plan: Development of New Parent Information Service

In attempting to deal with staff frustrations over the unsuccessful effort to implement PACER's component, a brain-storming session was held. During this session many ideas were tossed around for discussion, some of a serious nature while others were exaggerated and humorous in content. Ultimately this served as both a mechanism to release stress and led to a creative use of staff energy. From this exercise, which seemed to be futile at first, emerged a new plan which was called New Parent Information Service.

# NEW PARENT INFORMATION SERVICE: A MODEL FOR PREVENTION

## Introduction

The overall objectives of the program were as follows: (1) to introduce available community services to all parents of new infants who are interviewed; (2) to develop a method of early identification of families who seem to have a high probability of experiencing difficulties with the child-rearing process, or "families in need of services"; (3) to design and implement a method of ferreting "families in need of services" to appropriate resources; and (4) to develop a method of evaluating the long-range effects of such a program.

## Structure of the Program

Volunteers from the community were recruited, screened, and trained as Family Interviewers. Each volunteer agreed to interview twenty parents with new babies, discussing with the parents their reactions to parenthood and community resources which are available for their use.

1. Family Interviewers presented to each family a New Parent Information Packet which consisted of a list of services and brochures especially geared to the needs of parents with new babies, day-care services, and health care services, and other services geared to special family needs, such as family counseling, psychological services, etc.

2. The Family Interviewer completed with each family a questionnaire entitled "New Parent and the Community". The questionnaire is designed using criteria which assesses to some degree families who may be "at risk", or who are "in need of services" (These select criteria are based upon materials developed by Dr. Ray E. Helfer). Following each interview, the volunteer completed a "Parent-Child Interaction Check List", which is an assessment of non-verbal and verbal behaviors between the parent and child, and a Service Assessment Form, evaluating service needs of a family.

3. If a Family Interviewer and his PACER supervisor determined from the questionnaire and check-list that a family may be in need of services, the interviewer agreed to provide two or three follow-up home visits to that family in order to offer and direct them to an appropriate resource(s) in the community.

## Staffing of the Program

Volunteers were recruited from the community-at-large and were screened with an application and personal interview. Selection was based upon the following personal characteristics: realiability, maturity, warmth, and empathy. Volunteers were to be over twenty-one years of age and have their own transportation. Mileage costs were reimbursed.

## Training and Supervision

Training consisted of four one-half day sessions (12 hours) which included identification of potential problem areas, recognition of parental feelings, education regarding community resources, and practice interviewing. Films, slides, tapes, and role-playing are utilized extensively.

Follow-up group supervision was offered to all volunteers so that interviews and service recommendations would be reviewed.

## Selection of New Parent Names

Names of parents to be interviewed were randomly selected from the birth columns listed in local newspapers covering the county.

The months selected for interviewing parents were determined by the birth rate statistics recorded within the county from the previous five years and included the high birth rate month, the low birth rate month, and the average birth rate month.

## Evaluation of New Parent Information Service

The long-range effectiveness of the New Parent Information Service was evaluated through follow-up contacts with families. General feedback information was obtained regarding:

(a) the perception that interviewed parents have of the services six months later (1) after participation in services; (2) after non-participation in services ("hindsight").

(b) the receptibility of families to participation in services when services are introduced personally and immediately following delivery.

(c) the effect of personal contact in the introduction of services to families.

(d) the "needs" that families have developed six months following their original contact.

## Summary

It was hoped that the New Parent Information Service would (1) provide a means of acquainting families with community services and (2) develop a method of identifying families who have higher probability of experiencing difficulties with the child-rearing process, (3) develop a means of ferreting families "in need of services" to appropriate referral sources before serious problems arise, (4) learn more about the experience of new parenthood, and to identify more clearly services which may be beneficial to parents with new babies.

## Forms Used for New Parent Information Service

Three forms were designed for use by the volunteers. The first, "New Parent and the Community" was the questionnaire which covered questions relating to high risk factors and needed services. It included a permission slip for parent use.

The second form was a parent-child interaction check-list designed from observations an interviewer could make. This form did not provide consistent information since on some occasions, the baby was asleep, or in another room, only one spouse was home, while the other had left with the child.

The third form was a Service Assessment Check-list which summarized the problem areas covered in the basic questionnaire. It provided space for the interviewer to record the service recommendations he or she had made during the interview, or recommendations he or she planned to take back to the family at a later date.

## New Parent Information Packet

In assembling the New Parent Information Packet, sixty-five agencies were canvassed for packet information; twenty-five agencies responded with brochures and other pertinent information.

The following services were listed in the packet:

A. Child Management Classes and Parent Discussion Groups

Family Counseling Center
Pinellas County Schools
Parents Anonymous

B. Day Care Centers and Homes

Pinellas County License Board
Project Playpen

C. Emergency Assistance and Financial Aid

Food Stamp Office
Pinellas County Department of Social Services
General and Medical Services
Social and Economic Services
The Salvation Army

D. Family and Marriage Counseling

Child and Family Comprehensive Mental Health Center
Family Counseling Center
Lutheran Clinical Counseling Center
Marriage and Family Coulseling - JWB

E. Health Care Services

Children's Medical Services
Easter Seal Society for Crippled Children

E. Health Care Services (continued)

Homebound Program (PARC - retarded children)
Speech and Hearing Clinic
Free Clinic
Pinellas County Health Department

F. Special Clubs and Organizations

Childbirth and Parent Education League
Twin Mother's Club
Young Mother's League
LeLeche League
Y.W.C.A.

G. Information and Referral/ Emergency Crisis

Hotline (Alternative Human Services)
Information and Referral System

These services were listed in a directory and included (1) range of services, (2) fee scales, (3) addresses and phone numbers, (4) name of a contact person. Also included were colorful brochures and pamphlets describing some of the aforementioned services in more detail. A reading list for new parents was compiled and added to the packet.

The packet that was used was a two-pocketed plain gold folder with "New Parent Information Packet" printed on the front. Hopefully, it was presented in a more appealing fashion that would encourage the parent to keep the packet for future reference.

Recruitment of Volunteers

A variety of methods were used to recruit volunteers. Advertisements were placed in the newspapers for volunteers, posters were placed in the junior college, and the local branch of the University of South Florida, and at Eckerd College. Presentations were given to classes at all four schools. Recruitment was also tried at local clubs and social organizations, such as Young Mother's Club, the St. Petersburg Junior League, and the St. Petersburg Junior Woman's Club.

The method which drew the most response was the newspaper advertisements. Unfortunately, though the advertisement stated that volunteers were being sought, some persons who responded thought that a salary was involved.

Recruitment from clubs and organizations was very unsatisfactory; no volunteers were recruited.

Recruitment from the college campuses was somewhat disappointing, though a number of students expressed a good deal of enthusiasm for the program, most of them were carrying many class hours and felt that this was a prohibiting factor. Seven volunteers were recruited from this source and ranged in age between eighteen and forty-five. Of these seven, only one completed or attempted to complete all twenty interviews.

Another method of recruiting from campuses was attempted by contacting professors in various programs to arrange for class credit to be given to students who volunteered for this activity. An agreement was established with a professor of sociology at St. Petersburg Junior College. Four students were recruited and trained; however, their school term ended prior to their completing their interviews. The students received credit for participation in New Parent Information Service, but failed to return any questionnaires.

An additional volunteer from St. Petersburg Junior College, from the Human Services Program, served one term of her internship with PACER as a Family Interviewer and did complete the assigned interviews.

Number of Volunteers in Training

A total number of twenty-six persons began training as Family Interviewers in the 12 hour workshop. Twenty-five people completed the training which consisted of four three-hour sessions.

In order to accommodate the scheduling needs of the volunteers, seven workshops were held in order to offer training. (Two workshops were held in October; two in February; three in April.) A total of 84 hours was spent in training.

Profile of the Family Interviewer

In recruiting volunteers, it was recognized that New Parent Information Service, as a volunteer activity, appealed to a wide variety of people in the community, ranging from ages seventeen to seventy. From the coordinator's perspective, an unusually high percentage of persons who were interested in the program were those who were questioning their own childhood rearing process, those who had past difficulties in the rearing process, or those who were having current problems with their own off-spring. Out of the twenty-five volunteers who were selected, ten of them expressed strong comments about their own childhoods, or about feelings toward their own children, or spouses, which constitute characteristics associated with "high risk" parents. An even higher percentage of applicants who were screened but either unaccepted or dropped out exhibited the same characterisitcs.

Out of the twenty-five volunteers, nineteen were female and six were males. All were high school graduates; twelve were enrolled in college either part-time or full-time; one had two years of college, two were college graduates; three held master's degrees, (two in guidance and counseling; one in library science).

Fifteen of the twenty-five were married; six were single; two were divorced; and two were widowed.

Thirteen had children; five had grown children; six had no children; and one was expecting a child.

None were working full-time outside the home; eight were full-time homemakers; three were retired; two were working part-time and living with parents; seven were homemakers who were enrolled in school part-time; and five were full-time students.

The average age of the volunteers was 35.4 years.

## Volunteer Reaction to New Parent Information Service Training

The volunteers who participated in the workshop were very enthusiastic about the training. During the sessions, much discussion occurred which reflected a personal growth on the part of the volunteers. Indeed, an overwhelming majority of the volunteers not only felt they had developed insight into the nature of child abuse, but they also felt a development in their own self-awareness. The success of the training itself seems reflected in the nearly non-existant attrition rate.

It was hoped that this enthusiasm coupled with support from the coordinator and with a short-term time-limited assignment would lead to a high percentage of completed interviews. Unfortunately, this assumption did not hold true.

## Family Interviewer: Contacting Families

Major problems occurred in Family Interviewers making contact with families who were selected for interviews. (1) Because names were randomly selected from the newspaper, many of the addresses were incorrect. (2) Interviewers had difficulty locating specific families and addresses, which proved to be both time-consuming and discouraging to the interviewer. (3) Some of the families had moved since the birth of the child; forwarding addresses were not available. (4) Interviewers had some difficulty finding families at home when the contact was attempted.

These factors seemed to contribute greatly to the high drop-out rate of the volunteers. Particularly surprising to the volunteers and to the coordinator was the large amount of time required to locate and to make contact with the family.

## Number of Volunteers Completing Interviews

From the original twenty-five volunteers who were trained, eleven did not complete nor return any questionnaires nor report making any attempt to contact families. This constitutes 44 percent of the volunteers.

Five volunteers completed less than 10 interviews each and then withdrew from the program, constituting 20 percent of the volunteers.

Nine volunteers either contacted or made at least three attempts to contact their assigned families, which constitutes 36 percent of the volunteers.

No interviewer was able to make contact with all twenty families. (See "Family Interviewers: Contacting Families).

A total of 405 names were assigned. From that number 162 were completed, which is exactly a 40 percent return.

## Parent Reaction to the New Parent Information Service

From the reports gathered from the Family Interviewers who made contact with the families, their reception was generally very positive. The majority of the families were glad to receive a New Parent Information Packet and felt that it contained information which they did not obtain from their doctors or from their hospital. In regard to the questionnaire,

Parent Reaction to New Parent Information Service (continued)

the vast majority of parents who were contacted agreed to complete the interview and to answer the questions.

In instances in which the Family Interviewer was turned away from the home, the reasons seemed related to confusion over the role of the interviewer (was he or she really a salesperson, or did he or she have some other motive). Other reasons involved fear of strangers, or in one instance, a husband instructing his wife to admit no-one to the home. The most open rejection of the interviewer was from a wife of a pediatrician who did not feel any need for help.

By and large, the Family Interviewers who completed the majority of their interviews felt that families welcomed the opportunity to talk about the changes they had experienced in their lives since their new arrival. Often the problems which were focused upon by the parents were not those presented by the new baby, but involved difficulties with a sibling, an in-law, or some other aspect of the parent's life. This presented the interviewer with the opportunity to discuss other services, in addition to those within the New Parent Information Packet.

Some of the interviewers were invited back to visit the family when they were in the neighborhood. This was particularly true for the two oldest volunteers in the program, ages 67 and 70 respectively, who parents seemed to identify as a grand-parent figure for the family.

Family Interviewer Reactions to New Parent Information Service

The volunteers who completed either some interviews or made an attempt to contact all of their assigned families generally felt their experience with the actual interview was very positive. Many said they enjoyed meeting families who represented a cross-section of the economic classes, and indeed, a true variety of unusual families was discovered upon the random lists. Among these existed the following: a Japanese family who spoke little or no English, a genuine Hawaiian princess, a family residing in a log cabin, a family in a commune life-style, still another family residing on a houseboat. In terms of occupations, the range included pediatricians, nurses, teachers, attorneys, laborers, real estate agents, secretaries, the unemployed, etc. The uniqueness of this sampling seemed to have a broad appeal and offered a variety of experiences for the volunteer.

Generally, the volunteers who stayed with the program felt that New Parent Information Service was a valid and needed service in the community and seemed excited about being a part of a pilot program which they felt was innovative. For the most part, they like the New Parent Information Packet and felt it would benefit the family who received it.

In terms of the actual interviews themselves, the volunteers who attempted to complete at least some or all of their interviews felt that after their initial anxiety of introducing themselves to the family was over that the remainder of the interview was more pleasant, and in several instances, rewarding.

Certainly, frustration arose for the interviewers because the most receptive friendly families seemed to be those who the interviewer did not perceive as "high risk", while those families who were more reluctant, cautious, and less open were those who seemed to be having more problems and difficulties, and by their very nature, were less approachable.

However, many families who were interviewed did generally express genuine interest in services, day care homes and centers being the most frequently named. Again the interviewers felt pleased about the role of providing service information to the family and seemed to make real efforts to "sell" the value of services to all families. Generally, families who seemed more receptive to services were those who were perceived by the interviewer as the "working class", or those who were limited financially but were for the most part not eligible for public assistance programs.

Some unanticipated resistance from the interviewers arose in regard to completing the three required forms in New Parent Information Service. Although some of the interviewers did not object to the forms vocally, others did feel that the forms were too time-consuming. This factor contributed to the fact that some of the forms were only partially filled out or ignored.

Follow-Up Visits

Out of the nine volunteers who contacted or attempted to contact on at least three occasions their assigned families, only three made return visits to families who were identified as "in need of services". These three interviewers were those who were particularly involved in New Parent Information Service and who had some natural abilities and a very empathetic manner about them. Two of these three were women, ages 25 and 30 respectively, who were interested in pursuing social work as a career, but were not enrolled in a school program. The third, 33 year old woman, was a very talented medical technician who was trained in nursing and who was also interested in returning to school in a social work education program. All three of these women had a particular empathy for parents with babies and the difficulties related to the parent role; each was a mother with pre-school age children. (There appears to exist a need to be away from the home part of the day and to be involved in a volunteer activity which has a flexible schedule).

The remaining six volunteers who made the greatest effort to reach their families expressed a good deal of resistance to returning to the families who seemed to be in the greatest need for services. They felt that the parents who needed the most services did not seem to be aware of their problems and, therefore, they felt awkward and unable to make a re-entry into the home. Even though the interviewers did feel that the family had serious difficulties and needed help, they had fears and anxieties about approaching them again.

Their resistance seemed related to their lack of experience in interviewing and to the fact that methods of making return visits were not sufficiently covered in the training workshop. (It could also be pointed out that trained social workers have similar resistance to families whom they perceive to be unreceptive). Again the time consuming aspects of the visits and travel also contributed to the resistance of the volunteers.

## Evaluation of Follow-Up Contact Forms

### 1. Reasons for Follow-Up Visits

The reasons given by interviewers for follow-up visits included the following general categories: (a) highly anxious or nervous parent; (b) parent who expressed interest generally in community services or in a specific community resource; (c) medical problems with parent or infant; (d) parent who seemed to have difficulty in the attachment process; (e) parent experiencing family adjustment difficulties.

Some of the visits were requested by the parent; the majority of the visits were initiated by the interviewer.

### 2. Family Recommendations for Service

The following recommendations were made by interviewers at the follow-up visits:

| | |
|---|---|
| Child Management Classes | 3 |
| Legal Aide | 1 |
| Free Clinic | 2 |
| Parents Anonymous | 1 |
| Pediatrician | 1 |
| Project Playpen | 1 |
| Goodwill | 1 |
| Food Stamp Office | 1 |
| Home Health Aide | 1 |
| Child & Family Comprehensive Mental Health Center | 1 |
| Florida State Employment Office | 1 |
| Other | 2 |

### 3. Summary of Comments

Generally, the Family Interviewers expressed positive reactions in regard to their visits and felt the families who they visited had improved in their functioning. They did feel that in most instances the working relationship that had begun to develop between the family and themselves was helpful in service referral.

## Coordinator's Evaluation of New Parent Information Service

1. The concept of the program generally holds much merit and could be developed into a real method of early intervention with families who might later experience difficulties with the child rearing process.

2. The use of volunteers for such a program seems limited as reflected by the high attrition rate and the low number of completed interviews. The use of either full-time or part-time staff paid per interview would seem to be preferrable.

3. A big factor in this survey was the personality, skills, and empathy of the interviewer. More skilled interviewers were able to identify more family needs, conduct more thorough interviews, establish more rapport with families, and were more able to make return visits. This is evidenced throughout the returned questionnaires and seems to reflect the individual skills of each volunteer. Again, this seems to speak for the need for paid trained staff for this activity.

4. The New Parent Information Packet seemed to be well-received by families and was distributed to the parent at a point in time when the actual realities of caring for a new baby were beginning to hit. This kind of distribution seems preferable to distributing from the hospital setting, at a time when a parent is generally deluged with other pamphlets and materials.

5. The role of coordinator of New Parent Information Service entailed a significant amount of frustration since the responsibility of completing interviews, questionnaires, and follow-up rested with the volunteers. Even though the coordinator was convinced of the value of New Parent Information Service as a model for prevention, the high attrition rate for the volunteers was difficult to deal with and appeared to be a factor over which one had little or no control.

6. In presenting this idea to the community, there was a very positive response received from various community groups and professional agencies. Most people expressed enthusiasm for this program and thought it should be on a wide-scale basis. Only a handful of individuals expressed concern about the broad matter of confidentiality.

## PACER COMPONENT: NEW PARENT INFORMATION SERVICE

### Appendix of Forms

The attached forms were developed for use in various stages of New Parent Information Service.

I. Volunteers Needed for Pilot Community Program

II. Description and Role of Family Interviewer

III. Application for Interview

IV. Training Workshop for Family Interviewers

V. Interviewer Log.

VI. Suggestions for Introduction to New Parents

VII. Questionnaire: "New Parent and the Community"

VIII. New Parent Interaction Checklist

IX. Service Assessment

X. Follow-up Family Contacts

XI. Follow-up Evaluation: Cover letter and questionnaire

PACER
PARENT AND CHILD EFFECTIVE RELATIONS

juvenile welfare board of pinellas county 813/822-6661
3456 first avenue south • st. petersburg • florida 33711

executive director
Raymond L. Edwards, ACSW, Ph. D.

project director
Charlene G. Bennett

# NEW PARENT INFORMATION SERVICE

## Volunteers Needed for Pilot Community Program

PACER, a three-year federally funded demonstration and research project, sponsored by the Juvenile Welfare Board of Pinellas County, is presently recruiting and screening prospective volunteers to participate in a pilot program called New Parent Information Service which will soon begin operation in Pinellas County. Its over-all function, which we believe will be a very innovative service, is to acquaint parents of new borns with existing community services which are geared to their needs.

We are asking each volunteer to contract to interview twenty parents with new babies during a one-month period, discussing with each family their reaction to parenthood, its effects upon the family, resources currently available to them, and other areas covered in a new parent questionnaire. The volunteers will provide information regarding available services and will give each family a New Parent Information Packet. This packet will contain a list of services especially geared to parents with new babies, such as pre-natal classes, day-care and child management classes as well as additional brochures and information regarding services which focus on special family needs, such as family counseling, psychological services, health care, etc., which some families may find helpful.

Through this service we not only hope to acquaint families with helping services, but we also plan to develop a method of identifying families who appear to have a higher probability of experiencing difficulties with the child-rearing process. Part of the interviewer role will include making some follow-up contacts with those families in need of services in order to encourage them to avail themselves of appropriate community resources before serious problems develop. Through this method we also plan to assess to some degree types of services new parents might find helpful, but are currently unavailable within the community.

All volunteers for New Parent Information Service will be required to participate in four rather intensive half-day training sessions prior to interviewing. These sessions will include films, slides, tapes, and role-playing, and other materials which will cover identification of potential problem areas, interviewing methods, identification of parental feelings, community services, etc.



PACER is made possible through a grant from the Office of Chil (continued)

(continuation sheet 1.)

The interviewer role is time-limited in nature so that at the completion of the contract the volunteer may terminate participation in the program. However, a volunteer may choose to 're-contract' to interview a second designated number of new parents, depending on his/her interest.

In terms of personal qualities, we are interested in recruiting reliable, responsible, men and women over the age of twenty-one who are mature, warm, empathetic, willing to learn, and who recognize that parenthood, which can be a very rewarding life experience, can at times be very difficult and demanding for every parent. Related education or work-related experience would be helpful, but are not required. Each volunteer will need access to his/her own transportation and will need available time to participate in training and in consultations with PACER staff while in the program. PACER will be able to reimburse each volunteer for mileage expenses incurred to and from interviews at the rate of fourteen cents per mile.

If you feel that you would like to participate in this community service program, please complete the application and return it to:

PACER Project
Juvenile Welfare Board of Pinellas County,
3455 First Avenue South,
St. Petersburg, Florida 33711.

Attn: Carol Jofen - Assistant Project Director

After reviewing your application, we will contact you regarding your participation as an interviewer with New Parent Information Service.

If you would like further information, or if you have additional questions, please contact Carol Jofen, Assistant Project Director, at 822-6601, Ext. 220.

## NEW PARENT INFORMATION SERVICE

Description and Expectations for the Role of Family Interviewer.

### PERSONAL CHARACTERISTICS

1. Maturity, warmth, empathy, reliability.
2. Ability to assume responsibility.
3. Capacity to identify and recognize positive as well as negative aspects of parenthood.
4. Over twenty-one years of age.

### EDUCATION AND EXPERIENCE

Related education, work-related experiences, and/or personal experiences, are all helpful, but are not required.

Willingness to learn is essential.

### OTHER REQUIREMENTS

Access to own transportation.

### RESPONSIBILITIES OF FAMILY INTERVIEWER

1. Participate in four (4) one-half day training sessions.
2. Contract to interview twenty parents of new borns during a one-month peri
3. Complete the New Parent Information Service survey questions and distribu the New Parent Information Packet to each family interviewed.
4. Provide a follow-up visit or visits (2 or 3) with those families who appear to be in need of services.
5. Participate in scheduled consultations on a regular basis with a PACER staff member.

### CONTINUATION OR TERMINATION IN PROGRAM

The Family Interviewer may choose to re-contract for additional new parent interviews or may terminate from the program following the comple tion of the contract.

NEW PARENT INFORMATION SERVICE

INTERVIEWER LOG

RVIEWER NAME: _____

| ned | Family Name | Family Address | Date of Birth/ Sex | Hospital | Date of Interview | Other Information* |
|---|---|---|---|---|---|---|
| | | | | | | |
| | | | | | | |
| | | | | | | |
| | | | | | | |
| | | | | | | |
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| | | | | | | |
| | | | | | | |
| 84 | | | | | | |

*Includes unsuccessful attempts to contact, hours spent, any additional notations. May want to correlate this with mileage forms.

Suggestions for Introduction to New Parents

I'm Mrs. Smith from the New Parent Information Services, we are interviewing parents of new borns in Pinellas County.

We feel that after the baby is born, everyone pays attention to the baby, but not to the needs of parents.

We would like to talk to you about what your experience of becoming a parent has been like.

There are some community services for parents of new babies which may be helpful for you to know about. We have developed a packet of new parent materials with these services, phone numbers, etc.

We would like to get some ideas from you for kinds of services that might be helpful to you as a new parent, but may not be available in the community at this time.

Some experts say that they consider the birth of a new baby to be a crisis in a family (couple) since it has such an impact.

The New Parent Information Service is a pilot program so that not all new parents will be surveyed. Your name was randomly selected. We are also attempting to establish a need for such a program as New Parent Information Service.

PACER

New Parent Information Service

Application for Interview

Name_____ Age_____

Address_____

City_____ Zip_____

How long have you lived at your present address?_____

Previous address (if less than 5 years)_____

Telephone Number: (work)_____ (home)_____

Education: fill in number of years completed.

Elementary_____ Secondary _____ College_____

Other schooling: Specify_____

Marital Status: Single ___ Married ___ Separated ___ Divorced ___ Widowed ___

Family Status:

Spouse: living at home?_____

Children - living at home - ages_____

not living at home - ages _____

married - number_____

Reasons for applying:_____

Describe any serious physical or psychiatric illness you have had in the past few years._____

List hobbies, skills and interests:_____

To what religious, civic, or professional groups or clubs do you belong? _____

Have you had any work experience that you feel might aid you in interviewing parents of new infants? _____

Have you had any personal experiences which you feel might assist you in relatin to parents of new infants? _____

How many hours a week would be available for conducting interviews? _____

During what hours would you be available? _____

Specific time during week? _____ Weekends? _____

What do you see as problems that all parents of new borns might experience? _____

What should be done to people who abuse their children? _____

In general, how do you feel that children should be disciplined? _____

If you are a parent, what problems did you experience with your child when it was born? _____

Who helped you with these problems and in what ways? _____

Do you have a sense of humor? _____

What qualities do you feel are essential to be able to effectively relate to new parents? _____

Have you ever experienced severe anger with your children or with children other than your own? _____

Have you ever reached a point where you felt that a crisis was arising regarding your care of your children or with your care of someone else's children? _____

List any educational courses you have taken in psychology, child care, human relations: _____

Do you believe that a couple need to have children in order to be fulfilled? _____

What kind of experience would you like to have as an interviewer in the New Parent Information Program? _____

How do you feel that a mother or a father learns how to parent children? _____

When will you be available for training? _____

Do you have transportation available? _____

If you interviewed a family whom you felt would benefit from or needed a follow-up visit, or visits, would you be willing to pursue contact with the family?

NEW PARENT INFORMATION SERVICE

Training Workshop
for
Family Interviewers

COURSE DESCRIPTION

The purpose of this workshop is to train volunteers as Family Interviewers for the New Parent Information Service. The goals of the workshop are as follows:

1. to learn the etiology and dynamics of child abuse and of the potentially abusive parent

2. to learn to discriminate both verbal and non-verbal responses of parents "at risk".

3. to develop and refine basic interviewing skills needed in family interviewing.

4. to conceptualize the purpose, function, and goals of the New Parent Information Service and to integrate learned knowledge and skills through actual program participation.

The sessions are helf four times for three hours, a total of twelve hours. Four PACER members will train volunteers.

INSTRUCTORS - Charlene Bennett, Project Director, PACER

Carol Nofen, Assistant Project Director, MSW

Betty Royer, Education and Training Coordinator

Thom Shuman, Planning Technician, B.A.

## SESSION I - First Day (3 Hours)

### Session I - Introduction to Child Abuse and Neglect

A. "Children in Peril" and discussion

(a) Introduce Pacer and description of services

(b) Hand out PACER brochures — Approx. 45 mins

B. "World of Abnormal Rearing" Dr. Ray E. Helfer

(a) Hand out WAR Cycle

(b) Hand out New Parent and the Community Questionnaire following tape — Approx. 1 hour

C. The assessment the Family Interviewer will be making is based on:

(a) The presence of the WAR cycle within the family

(b) the family's capacity to bail out

(c) the parents' perception of the child

(d) the presence of stress factors which contribute to the probability of a crisis, such as marital conflict, economic problems, illness, baby's behavior, etc.

D. 15 Minute Break

E. "Mother-Infant Interaction" video tape

(a) Hand out packet of attached materials which include a description of the original maternity ward monitoring component, "Early Identification of Parents-at-Risk", et al.

(b) Hand out Parent-Infant Interaction Check List

(c) Hand out Role of Volunteer decsription

(d) Explain the operation of New Parent Information Service

(e) Link NPIS to role of the volunteer in "bailing out". — Approx. 1 Hour

F. Explain identifying "parents-at-risk".

(a) Observing interaction and non-verbal responses

(b) appropriate and inappropriate verbal response

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Carol Nofen, Assistant Project Director, MSW

Betty Royer, Education and Training Coordinator

Thom Shuman, Planning Technician, B.A.

## SESSION II - Second Day (3 Hours)

| | | |
|---|---|---|
| A. | "Child Abuse" Part I<br>Slide Presentations & Discusssion | Approx. 1 Hour |
| B. | Shirley Radl Tapes<br>"Social Pressure and the Overwhelmed Parent" and discussion | Approx. 30 Mins |
| C. | 15 Minute Break | |
| D. | "The Abused Child Grows Up" and discussion | Approx. 30 Mins |
| E. | Florida Law and Reporting Procedures | Approx. 45 Mins. |

## SESSION III - Third Day (3 Hours)

A. New Parent Information Packets and Services

Hand out packets and go over brochures and directory

Approx. 30 mins.

B. Distribute one of each and explain:

Interviewer Log
New Parent and Community Questionnaire
Parent Interaction Check List
Service Evaluation
Service Assessment
Follow-up contact form
Copy of introduction to family
Mileage Form
Copy of Kagan response modes

Approx. 15 mins.

C. Review

D. Break - 15 minutes

E. Interviewing Skills

Begin Kagan Training and Response Modes;
"Interpersonal Process Recall

## SESSION IV - Fourth Day (3 Hours)

| | | |
|---|---|---|
| A. | Kagan Empathy Training "Interpersonal Process Recall" continued | Approx. 90 Mins. |
| B. | 15 Minute Break | |
| C. | Role playing and practice session in interviewing new parents | Approx. 1 Hour 15 Mins. |

To you, the new parent:

As a part of a pilot program Family Interviewers are meeting with parents of new borns in Pinellas County and are distributing New Parent Information Packets which contain listings of community services, resources, and organizations which should be of a particular interest to parents with new babies.

As a part of developing the New Parent Information Service, each Family Interviewer will be asking your help in completing a New Parent and the Community Questionnaire to help us learn more about what the experience of becoming a parent is like, what resources and services have been available to you, and generally, the kinds of changes that you've experienced now that your new arrival is at home.

From this information we hope to gain insight into special needs that new parents have so that we can determine which community services are most helpful for new parents. We also hope this information will help us to better plan for the development of special community services which are particularly geared to the new parent.

NEW PARENT INFORMATION SERVICE

New Parent and the Community Questionnaire

for

Parents of New Babies

1. What has been the greatest change you've experienced in your home now the baby is here? Did you anticipate these changes.

_____

_____

_____

2. Did you attend pre-natal classes?

_____ Yes _____ No

Were they helpful?

_____ Yes _____ No

Additional Comments: _____

_____

3. Many parents feel that the present educational system does not teach parenting, Do you feel you received any education in school on how to parent?

_____ Yes _____ No

If not, where do you feel you obtained most of your information?

_____

Did you babysit? Did you care for younger brothers or sisters?

_____

4. Did you attend hospital classes?

_____ Yes _____ No.

5. Are you attending post-partum classes now?

_____ Yes _____ No

Do you feel they might be helpful?

_____ Yes _____ No

6. Do you have a doctor?

_____ Yes _____ No

Is he receptive to calls regarding your questions?

_____ Yes _____ No

7. Who gets up in the middle of the night when the baby cries?

_____

8. How has your wife/husband adjusted to the baby?

_____

9. How have other children in your family adjusted to the baby? Do they help?

_____

10. A big problem in Pinellas County is that many families are from out of town so that they don't have relatives or froends to call here. Do you have relatives or friends in this area to call or to help with the baby?

_____ Yes _____ No

Do you have anyone to use as a babysitter?

____ Yes _____ No

11. We would like to assess the need for a Dial-A-Mom Service. This service is a 24 hour telephone line operated by experienced parents who answer questions new parents have about their babies.

Would this be a service you feel you might use?

_____ Yes _____ No

12. How is your baby's health? Does it have colic or diarrhea?

_____

13. What was your first reaction to the baby? Who does the baby look like? Does it look like you thought it would?

_____

_____

14. Are you breast feeding or bottle-feeding your baby? How did you decide on a method?

_____



_____

15. When is the baby the fussiest?

16. What is the baby's name? How did you pick it out?

17. Did you want a boy or girl?

18. What was your pregnancy like for you as husband/wife?

19. What was your husband's/wife's reaction to the pregnancy?

20. What was your method of delivery? How was it selected? Was your husband present at the delivery?

21. How is your health since the baby's birth?

22. Many couples have a lot of fears about being parents, particularly for the first time. Has that been your experience?

23. What has been the most satisfying thing about having the baby home? Least satisfying thing?

24. How do your parents feel about the baby? Were they anxious for grandchildren? Are they helpful?

25. Do you plan to raise your child the way you were raised?

_____ Yes _____ No

What would you do differently?

_____

_____

What would you do in the same way?

_____

_____

26. Looking over the whole experience so far, what advice or suggestions would you offer to other expectant parents or couples who are considering whether or not to have a baby?

_____

_____

_____

Number of children_____

Ages_____

I am willing to participate in an interview with a Family Interviewer from the New Parent Information Service in completing a New Parent and the Community Questionnaire.

I understand that information I give is confidential and will be used by the New Parent Information Service for their assessment of family and community needs. Any data released will not contain identifying information.

_____

Mother

_____

Father

_____

Date

## NEW PARENT INTERACTION CHECK LIST

ease check all applicable responses that are observable.

| | Mother (Substitute) | Father (Substitute) |
|---|---|---|
| Perceives child as attractive or appealing. | | |
| Perceives child or some part of child, as unattractive or ugly. | | |
| Holds child close to own body. | | |
| Holds child away from own body. | | |
| Makes frequent eye contact with infant | | |
| Avoids making eye contact with infant | | |
| Thinks child is physically and emotionally healthy. | | |
| Believes child has some serious disease or is emotionally disturbed, despite negative findings. | | |
| Coos or talks to infant. | | |
| Fails to coo or talk to infant. | | |
| Supports infant's head | | |
| Leaves infant's head dangling; does not support head. | | |
| Does not find odor of child unpleasant or offensive. | | |
| Thinks of the odor of child as "smelly" or revolting. | | |
| Shows joy or pleasure when feeding, cuddling, or changing infant. | | |
| Demonstrates anger or displeasure at feeding, cuddling or changing infant | | |
| Makes positive statements about infant, "he looks like me", "she's so cute", etc | | |

| | Mother (substitute) | Father (substitute) |
|---|---|---|
| Makes negative statements about infant, "he looks like me, poor kid", "it looks like an ape", etc. | | |
| . Demonstrates interest both verbally and non-verbally in holding or caring for infant. | | |
| Expresses verbally or non-verbally a lack of interest in holding or caring for infant. | | |

MMENTS:

NEW PARENT INFORMATION SERVICE

Service Assessment

I. Question Evaluation

1. Basic level of experience and knowledge of child care:

___ No experience

___ Limited experience

___ Some experience

___ Much experience

___ Attended pre-natal classes

___ Attends post-partum classes

___ Attends child management classes

2. Resources available to family:

___ Relatives in community who help

___ Friends in community who help

___ Couple rely on each other

___ Other children in family help

___ Helping services in community are involved

___ No friends or relatives in community

___ Would use other resources, if they were available.

3. Parental feelings expressed toward infant and its behaviors:

| | Mother (or substitute) | Father (or substitute) |
|---|---|---|
| All positive | ____ | ____ |
| Mostly positive | ____ | ____ |
| Somewhat positive | ____ | ____ |
| Mixed-ambivalent | ____ | ____ |
| Somewhat negative | ____ | ____ |
| Mostly negative | ____ | ____ |
| All negative | ____ | ____ |

4. Family Adjustment to change (their view):

___ Excellent adjustment, no problems

___ Well adjusted, accept problems

___ Adjusted, attempting to accept problems

___ Attempting to adjust

___ Poor adjustment, little acceptance of problem

___ No adjustment to change

5. Preparation for Parenthood:

___ Spent extensive time in preparation

___ Spent much time in preparation

___ Spent some time in preparation

___ Spent almost no time in preparation

___ Spent no time in preparation

6. Feelings toward past childhood experiences:

| | Mother (or substitute) | Father (or substitute) |
|---|---|---|
| All positive | ___ | ___ |
| Mostly positive | ___ | ___ |
| Somewhat positive | ___ | ___ |
| Mixed feelings | ___ | ___ |
| Somewhat negative | ___ | ___ |
| Mostly negative | ___ | ___ |
| All negative | ___ | ___ |

7. Indications of WAR Cycle:

| | Mother (or substitute) | Father (or substitute) |
|---|---|---|
| No indications | ___ | ___ |
| Limited indications | ___ | ___ |
| Some indications | ___ | ___ |
| Much indication | ___ | ___ |
| Many indications | ___ | ___ |
| Information not available | ___ | ___ |

8. Does this family have a pet?

___ Yes ___ No

9. Does this family have a listed telephone number?

___ Yes ___ No

II. Evaluation of New Parent Check List:

| | Mother (or substitute) | Father (or substitute) |
|---|---|---|
| No. positive observations made. | ____ | ____ |
| No. of negative observations made | ____ | ____ |
| No. of items unobserved | ____ | ____ |
| Parent or substitute not present | ____ | ____ |
| Total | _____ | _____ |

III. Special Family Needs Assessment:

A. Number of other children in home and ages: _____

_____

B. Special Family Needs: _____

_____

_____

IV. Family Service Recommendations:

A. Services: _____

_____

B. Service needed but not available in the community: _____

_____

_____

C. No service recommendations needed: _____

V. Additional comments: (please comment if family is already involved in service).

_____

_____

Family Interviewer



Project PACER

NEW PARENT INFORMATION SERVICE

Family Interviewer

Follow-Up Family Contacts

Name of Family _____

Address _____

_____

Reason(s) for Follow-up visit(s): _

_____

_____

_____

_____

_____

Objectives of visit(s):

_____

_____

_____

_____

_____

_____

Family Recommendations for Services:

_____

_____

_____

_____

_____

Evaluation of Home Visit(s):

Date: _____

_____

_____

_____

Date: _____

_____

_____

_____

Comments:

_____

_____

_____

_____

_____

_____

_____ _____

Project PACER Family Interviewer

_____ _____

Date Date

PACER
PARENT AND CHILD EFFECTIVE RELATIONS

juvenile welfare board of pinellas county 813/822-6661
3301 first avenue south • st. petersburg • florida 33711

executive director
Raymond L. Edwards, ACSW, Ph. D.

project director
Charlene G. Bennett

October 8th, 1976.

Dear

Juvenile Welfare Board's PACER Project is developing a new community service within Pinellas County for parents with new babies called New Parent Information Service. The purpose of this program is to tell new parents about community services that are free or on a sliding fee scale basis that might be helpful to them and their family. Family Interviewers visit families and give each family a New Parent Information Packet which includes local services and agencies.

You, as a parent with a new baby, are the expert we need in planning and developing community services for new parents in Pinellas County. We need your help, suggestions and ideas.

We would greatly appreciate you taking time to complete the questionnaire and returning it in the self-addressed stamped envelope to our office.

I am looking forward to receiving your comments and suggestions for our local program. Please feel free to contact me if you have any suggestions about New Parent Information Service, or about any other community service in which you might have some interest. My telephone number is 822-6661.

Sincerely,

Carol J. Nofen
Assistant Director
PACER Project

CJN/nc

## NEW PARENT INFORMATION SERVICE

Parenthood is one of the world's toughest jobs. We feel that our community should provide helping services, education, and information to all new parents. Oftentimes services parents might use are available in the community, but parents do not know what services there are, or how to reach them.

We would like to continue providing information to new parents and we need your help and suggestions.

Please check the following:

1. Are you using or have you used any community resources or helping services in Pinellas County since your child was born?

_____ Yes _____ No

2(a) Have you contacted or used any of the following services or clubs? Please check:

_____ Child Management Classes

_____ Day Care Center/Home

_____ New Parent Discussion Groups

_____ Child & Family Comprehensive Mental Health Center

_____ Childbirth & Parent Education League

_____ Marriage & Family Counseling - Juvenile Welfare Board

_____ Children's Medical Services

_____ Pinellas County Health Department

_____ LaLeche League

_____ Free Clinic

_____ Information & Referral/Hotline

_____ Young Mother's League

_____ Financial Assistance

_____ Other _____

_____

(b) Do you feel this service or services were:

_____ Extremely Helpful

_____ Very Helpful

_____ Of Some Help

_____ Little Help

_____ No Help

3. If you have not used a community resource or service since your child was born, do you feel there is a helping service you would use at this time?

_____ Yes _____ No

If Yes, which service would you be interested in? (Specify): _____

_____

_____

4. Do you feel that a visit by a Family Interviewer and a New Parent Information Packet would have been helpful to you when your baby was born?

_____ Yes _____ No

Please comment: _____

_____

_____

5. Do you feel that New Parent Information Service would be helpful to:

_____ All New Parents _____ Some New Parents

_____ Most New Parents _____ No New Parents

6. Comments: _____

_____

_____

_____

## NEW PARENT INFORMATION SERVICE

Parenthood is one of the world's toughest jobs. We feel that our community should provide helping services, education, and information to all new parents. Oftentimes services parents might use are available in the community, but parents do not know what services there are, or how to reach them.

We would like to continue providing information to new parents and need your help and suggestions:

Please check the following:

1. The community service information in the New Parent Information Packet was:

| | |
|---|---|
| _____ Extremely Helpful | _____ Of Little Help |
| _____ Very Helpful | _____ No Help |
| _____ Of Some Help | |

2. (a) Are you using or have you used any community resources or services in your New Parent Information Packet?

| | |
|---|---|
| _____ Yes | _____ No |

If yes, please check:

| | |
|---|---|
| _____ Child Management Classes | _____ Pinellas County Health Department |
| _____ Day Care Center-Home | _____ LaLeche League |
| _____ New Parent Discussion Groups | _____ Free Clinic |
| _____ Child & Family Comprehensive Mental Health Center | _____ Information & Referral/Hotline |
| _____ Childbirth & Parent Education League | _____ Young Mother's League |
| _____ Family & Marriage Counseling - Juvenile Welfare Board | _____ Financial Assistance |
| | _____ Other _____ |
| _____ Children's Medical Services | _____ |

(b) Do you feel these services are (or have been):

| | |
|---|---|
| _____ Extremely Helpful | _____ Of Little Help |
| _____ Very Helpful | _____ No Help |
| _____ Of Some Help | |

3. If you have not used a community service or resource since your child was born, do you feel there is a helping service you would use at this time?

_____ Yes _____ No

Which service? (Please specify): _____

_____

4. Do you feel that talking with the Family Interviewer was:

_____ Extremely Helpful _____ Of Little Help

_____ Very Helpful _____ No Help

_____ Of Some Help

5. Do you feel that New Parent Information Service would be of help to:

_____ All New Parents _____ Some New Parents

_____ Most New Parents _____ No New Parents

6. What suggestions would you make for improving New Parent Information Service?

_____

_____

_____

_____

_____

7. Comments: _____

_____

_____

_____

## RESULTS OF THE FOLLOW-UP EVALUATIONS

A. Those Families Who Received an Interview and a Packet

Item #1. The community service information in the packet was:

| | |
|---|---|
| 26.9% | extremely helpful |
| 34.6% | very helpful |
| 30.7% | of some help |
| 4.0% | of little help |
| | no help |
| 4.0% | help for a new mother |

Item #2a. Are you using or have you used any community resources or services in your New Parent Information Packet?

| | |
|---|---|
| 46.2% | Yes |
| 53.8% | No |

If yes, please specify:

Childbirth and Parent Education League
Pinellas County Health Department
St. Anthony's Hospital Classes
LeMaze Classes
Free Clinic
Children's Medical Services
Day Care Homes/Centers
Financial Assistance

Item #2b. Do you feel these services are or have been:

| | |
|---|---|
| 34.6% | extremely helpful |
| 15.3% | very helpful |
| 15.3% | of some help |
| 4.0% | of little help |
| | no help |
| 30.7% | no answer |

Item #3. If you have not used a community service or resource since your child was born, do you feel there is a helping service that you would use at this time?

| | |
|---|---|
| 37.0% | Yes |
| 41.0% | No |
| 22.0% | No answer |

If yes, please specify service:

Public Health Department
Day Care Center/Homes
Information Hotline
New Parent Discussion Group
Family and Marriage Counseling
Childbirth and Parent Education League
Young Mother's League
Financial Help

Item #4. Do you feel that talking with the Family Interviewer was:

| | |
|---|---|
| | Extremely helpful |
| 46.0% | Very Helpful |
| 27.0% | Of some help |
| 19.0% | Of little help |
| 8.0% | No help |

Item #5. Do you feel that the New Parent Information Service would be of help to:

| | |
|---|---|
| 31.0% | All new parents |
| 42.0% | Most new parents |
| 23.0% | Some new parents |
| | No new parents |
| 4.0% | No answer |

Evaluation of Comments of Families Receiving an Interview and a Packet

A review of the comments expressed such positives as, "Thanks for providing a stepping stone for parents to use for our future and the future' of our children"; "It made me feel good to know these services are available if we should need them"; "keep up the good work"; "Thanks for making it available to us".

Some parents felt that most parents do not know that so many services are available and that "it would be very beneficial to new parents if they only knew". Another stated that although they had need for services at this time they felt it was "good to know when the time arises".

In regard to the interviewer, following comments were received: "Very impressed with the politeness and over-all attitude of the interviewer"; "the volunteer was very nive and interesting"; and "very helpful".

In regard to the packet, one parent commented "it was very informative for future reference", another stated that the packet was "most helpful and informative .. although we haven't used any of the services or clubs, we have referred some of our friends to them ... we only learned about them through your visit and packet".

More negative comments were made by some parents, such as a registered nurse with three children, who felt that the information was geared to the lower class. Another negative comment came from a mother who felt that it is the responsibility of the parent to obtain service information and should not be that of a tax payer.

Others also felt that the material was geared to lower income families.

Suggestions Made by Parents who were Interviewed and Received a Packet

1. Extensive suggestions for improving techniques of childbirth classes through the maternity clinic.

2. Suggest providing information before birth of the child.

3. Suggest New Parent Information Service have a telephone listing. Personal interviews are not necessary.

4. Insist on some training before first child arrives.

5. Make service available to first-time parents and parents in this area less than a year.

6. Suggest a central location where parents could call to find out about treatment for special diseases and illnesses which cannot be handled locally.

B. Those Families Who Did Not Receive a Packet or an Interview

Item #1. Are you using or have you used any community resources or helping services in Pinellas County since your child was born?

41.0% Yes
59.0% No

Item #2a. Have you contacted or used any of the following services or clubs?

Childbirth and Parent Education League
Child and Family Comprehensive Mental Health Center
Pinellas County Health Department
Free Clinic
LaLeche League

Item #2b. Do you feel this service or services were:

24.0% Extremely helpful
17.0% Very helpful
Of some help
Of little help
No help
59.0% No answer

Item #3. If you have not used a community resource or service since your child was born, do you feel there is a helping service you would use at this time?

21.0% Yes
55.0% No
24.0% No answer

If yes, please specify:

New Parent Discussion Groups
La Leche League
Child Management Classes
Free Clinic
Financial Assistance
Day Care Centers/Homes
Children's Medical Services
Health Department

Item #4. Do you feel that a visit by a Family Interviewer and a New Parent Information Packet would have been helpful to you when your baby was born?

38.0% Yes
21.0% No
41.0% No answer

Item #5. Do you feel that New Parent Information Service would be helpful to:

27.5% All new parents
27.5% Most new parents
31.0% Some new parents
No new parents
14.0% No answer

Comments of Families Not Receiving a New Parent Information Interview or Packet

A review of the comments expressed such positive comments as follows:

"This service we feel is very helpful and necessary for most new parents and would be welcomes"; "Please send me a Packet and I'll let you know what I think"; "Thank you for your interest"; "Can you refer me to someone ... I would greatly appreciate it"; "The only one (service) I have used is the shots clinic ... really don't know about others, but would like to ... I never heard of this project, but am all for it because of low income it's hard sometimes"; "Didn't know such services were offered"; "We recently moved here and were unaware".

Another parent expressed that fact that they had previously resided in another community without services, such as LeMaze classes and the La Leche League. They stated they took advantage of them here and recommended all parents to do the same ... "the help was extremely valuable".

And finally, these comments were made by a former teacher and mother of four: "Your intent is important in that your goal is to reach those who might be in a young-age bracket and not quite sure "how to cope", there are many, many, many parents out there that we must reach and help to understand the complexities of child-rearing from the very beginning".

Many of the parents who expressed negative feelings about New Parent Information Service felt that the service would be beneficial for first-time parents, but not for second or third-time parents. Other parents did not feel the need for help or services, stating the following: "My mother is an R.N., plus a mother of four, so she was all the help I needed"; "the information is very informative for some new parents or newcomers to the area, but we were aware of all the facilities"; "I've never needed any of these services"; "We have not had a need for it as yet"; "Both of us being teachers, we are very versed in child management, education, mental health, etc."

A final comment was made by a parent who felt negatively toward NPIS: "Our problems are not baby care or feeding, money is the problem".

## SUMMARY OF THE FOLLOW-UP EVALUATIONS

New Parent Information Service was significant in providing a wider knowledge of services available to those interviewed, as compared to the responses of the non-interviewed group (Question #2). Those interviewed also expressed a higher willingness to use services in the future, though both groups indicated they would use similar services (Question #3).

The interviewed group predominantly felt that talking with the family interviewer and the material in the NPIS packet was of help. Interestingly, the majority of the non-interviewed group indicated that they felt a visit by an interviewer and receiving a NPIS Packet would have been helpful (Question #4). Both groups felt that NPIS would be of help to most, if not all, new parents (Question #5).

APPENDIX F

Law Intern Program

## Summary of the Law Intern Program

Problem:

Currently the Regional Office of the Division of Family Services does not have access to the use of legal representation through the State Attorney's Office in the processing of contested dependency affidavits filed in Juvenile Court. For that reason, the Division of Family Services must purchase the services of private attorneys with their own funds in all situations in which legal representation is deemed. Difficulties have arisen because of their limitation of funds and because they have had to utilize the services of various attorneys who are inexperienced in juvenile court legislation and in processing dependency affidavits.

Objective:

A more coordinated system of legal process would be beneficial and therefore, it is recommended that a program be developed that would provide greater consistency and routine procedures which facilitate rather than impede the use of the legal system by the Division of Family Services.

Recommendations:

In oreder to meet these objectives, it is recommended that a law intern program be implemented through an agreement between PACER (under the auspices of the Juvenile Welfare Board), and the Office of the State Attorney.

The State Attorney's Office would agree to screen and employ three law interns and provide for their supervision in preparation of all contested dependency affidavits for court presentation on behalf of Pinellas County residents. The State Attorney's Office would also agree to provide a staff attorney to represent Division of Family Services at the actual court hearing and to supervise case preparation by the interns.

PACER would agree to provide a revolving fund for salaries of law interns employed within the program and would be allowed access to statistical records in order to pursue their research efforts.

Rationale:

The obvious advantage of this approach as opposed to the existing one is that of locating responsibility with one assistant attorney who can develop expertise and sophisticate procedures as he deals with the complexity of dependency affidavits. Such sophistication cannot develop when various independent attorneys briefly are cast into the prosecutory role in a field where their familiarity with the applicable law is limited. Every place in the country where a system has developed that results in the processing of abuse and neglect cases in a manner that minimizes hostility and results in a treatment approach to parents and the insurance of safety for children, it has been accomplished only through dedicated endeavor on the part of the states' designated legal arm. We would like to see Pinellas County take the lead in Florida in this process.

Operation: (The following is excerpted from our 1975 refunding request and should provide an overall picture of the intern program.)

The current year report outlines the agreement which will provide for law interns to prepare dependency cases for the Division of Family Services, the State Attorney's Office being reimbursed by PACER at the rate of $500.00 per month for 3 interns. This program will go into operation immediately upon signaturing, probably by March 1st, 1975. It is expected to continue throughout the duration of the project. All parties seem satisfied with the Agreement and anticipate that it will sophisticate the processing of child abuse and neglect cases which must go through court and enhance the quality of service to both children and parents. A copy of the unsigned Agreement is included at this point and specifies details for the operation of this component during the remainder of the project.

Completion: (The following is excerpted from our 1976 refunding request.)

The essence of the law intern program and a copy of the contract were included in last year's refunding material. The contract specifies its continuation procedures and there is no need to repeat. All parties are pleased with the agreement and it will continue as is throughout the project. We are quite pleased with the qualitative progress that this agreement has produced. Social and Economic Services is receiving much better representation in court and is happy to at last have an advocate. Over and above the contract, the State Attorney's Office has provided both formal and informal training to Social and Economic Services in legal aspects. This will continue during the third year. By the end of the project, even though PACER money stops, there are good odds that the programs will not. It is doubtful that either party can return to their old methods, and it is likely that wheels for a better system are firmly in motion.

PACER PROJECT AGREEMENT WITH THE OFFICE
OF THE STATE ATTORNEY FOR THE SIXTH
JUDICIAL CIRCUIT

THIS AGREEMENT, entered into this _____ day of _____ A.D. 1975, by and between the Juvenile Welfare Board of Pinellas County, Florida, "PACER" Project, herein referred to as "PACER", and the office of the State Attorney for the Sixth Judicial Circuit hereinafter referred to as "State Attorney".

WITNESSETH:

WHEREAS, it is the desire of "PACER" to contract with the "State Attorney" to pursue the implementation of a legal intern program,

IT IS, THEREFORE, in consideration of the mutual undertaking and agreements hereinafter set forth, agreed between PACER and the State Attorney for the Sixth Judicial Circuit as follows:

I. THE STATE ATTORNEY FOR THE SIXTH JUDICIAL CIRCUIT AGREES:

A. Services to be provided:

1) to represent the Division of Family Services in Court in all contested dependency affidavits which are filed in Juvenile Court by the Division of Family Services on behalf of Pinellas County clients.

2) To employ law students to assist the State Attorney in preparation of contested dependency cases for court presentation. The State Attorney shall hire three (3) law students. Each student is to be employed 14 hours per week at an approximate salary of $166.67 per month. The State Attorney has sole right to alter the number of students employed in order to conform to his needs.

3) To provide PACER with a statement of expenditures on or before the 20th day of each month covering the period through the 15th day of the reporting month, which reflects financial records that sufficiently and properly reflect the name of the student, man hours worked and salary paid. Said statement shall be certified true and correct and signed by a responsible official.

4) To return to PACER any funds or part thereof not expended for the aforementioned services at the termination of the agreement.

5) To act as an Independent Contractor and not as an employee of the Division of Family Services and/or PACER in performing the aforementioned services.

6) To allow PACER access to statistical records that the State Attorney may accumulate in performance of this Contract order that PACER may pursue their research efforts in accordance with Federal requirements under which it operates.

II. THE PACER PROJECT AGREES:

A. Service to be provided:

1) To provide a revolving fund of five hundred dollars ($500.00) per month for the salaries of law interns who shall assist the State Attorney in preparation of contested dependency cases for court presentation.

2) To forward to the office of the State Attorney the aforementioned funds the first Thursday of each and every month for the duration of this agreement. The first $500.00 shall be provided on or about March 6th, 1975.

III. PACER AND STATE ATTORNEY MUTUALLY AGREE:

A. Effective Date

1) This agreement shall begin on March 1st, 1975, if the same has been signed by all parties to the agreement prior to the aforementioned date; if same is not signed by all parties to the agreement prior to the aforementioned date, purchase of services under this agreement shall begin on the date all parties to the agreement have signed.

2) It is the intent of the parties involved that this agreement shall end on April 30th, 1977. However, to remain within the statutory authority of the Juvenile Welfare Board, annual agreements will be completed to cover the Juvenile Welfare Board fiscal year October 1st - September 30th. This agreement shall cover the period from March 1st, 1975 through September 30th, 1975.

B. Termination

1) Termination at Will. All of this Agreement, or designated services purchased by this agreement, may be terminated by either party at any time, with or without cause, upon no less than thirty (30) days notice in writing to the other party. Said notice shall be delivered by certified mail, telegram, or in person.

2) Termination Because of Lack Of Funds. It is further agreed that in the event fu to finance this agreement, or part of this agreement, become unavailable the obligations of each party hereunder may be terminated upon no less than thirty (30) days notice in writing to the State Attorney. Said notice shall be delivered by certified mail, telegram, or in person. PACER shall be the final authority as to the availability of funds.

C. Termination Arrangements

After receipt of a notice of termination and except as otherwise directed, the State Attorney shall:

1) Stop work under the agreement on the date specified in the notice of termination.

2) Prepare all necessary reports and documents required under the terms of the agreement up through the day of termination, including the final report due at the end of the project, if any, without reimbursement for services rendered in completing said reports beyond termination date if said reports are not completed prior to termination date.

3) PACER shall reimburse the State Attorney for the services rendered upon and including the date of termination of the agreement.

4) PACER shall reimburse the State Attorney for services rendered that necessarily extend beyond the termination date of the agreement. The State Attorney shall notify PACER of such services within the thirty (30) day termination period and include an estimate of anticipated reimbursement expenses and an explanation of the need for services beyond the termination date.

D. Renegotiation or Modification

Any alterations, variations, modifications or waivers of provisions of this agreement shall be valid only when they have beed reduced in writing, duly signed and attached to the original of this agreement. The parties agree to renegotiate this agreement if federal revision of any applicable laws or regulations makes change in this agreement necessary. The parties also agree to renegotiate the terms of this agreement when either party to the agreement deems renegotiation or modification necessary.

E. Name of Payee

The name of the official payee to whom the Juvenile Welfare Board shall issue checks shall be: _____

_____

F. All Terms and Conditions Included in Agreement

This agreement contains all the terms and conditions agreed upon by the parties. No other agreements, oral or otherwise, regarding the subject matter of this agreement, shall be deemed to exist or to bind any of the parties hereto.

IN WITNESS WHEREOF, the parties hereto have caused this _____ page agreement to be executed by their official hereunto duly authorized.

JUVENILE WELFARE BOARD OF PINELLAS COUNTY

_____
Date

By: _____
Chairman

OFFICE OF THE STATE ATTORNEY FOR THE Sixth Judicial Circuit

_____

By: _____
The State Attorney

APPENDIX G

Child Management Classes

## CHILD MANAGEMENT CLASSES COMPONENT

In November, 1974, PACER staff approached the Pinellas County Adult Home Economics Director, Mrs. Virginia Schifferl, to initiate parenting classes. The hope was that some abusive families might be helped in a non-threatening way. The other facet was that by publicity on TV and newspaper articles, parents who were potential abusers or "high risk" but unknown to agencies might learn skills of parenting before having an incident. The classes were well received, in the beginning, due to the personality of Mrs. Mona Edwards, the original teacher. Pinellas County Adult Home Economics Department sent Mrs. Edwards to Atlanta for five days to take the trainer's course in Dr. Gordon's P.E.T. (Parent Effectiveness Training). The classes were not totally P.E.T. because that would have required a $50.00 fee for the participants. Instead, this was used in conjunction with nutrition, health and child-rearing techniques.

In the fall of 1975, four classes were initiated, the response was excellent. Mrs. Edwards taught three of them.

With the growth of these classes, the Department felt that Mrs. Edwards needed supplemental teachers so that classes might be given elsewhere in the county. Marge Parvin and Cheryl Nelson were trained by Mrs. Edwards to take the classes up-county and at Dixie Hollins High School Adult Education Center. They did not succeed.

PACER's role was to supply publicity to the newspapers by which, it was hoped, the people who needed the classes might be reached. This did prove effective, but after the first several classes, registration dropped. In some instances, the classes were cancelled.

Being the liaison person for the classes, my question has been and remains: Is the Adult Home Economics teacher equipped, in her training and experience, to handle the balance needed in such matters. The family relationships are intricate and I, personally, do not think the Home Economics degree prepares one for the material which comes up in these type parenting classes. Mrs. Edwards has a vivacious approach to teaching, and is sensitive to parents' needs. By her own personality and innate ability to relate to problem families, Mrs. Edwards has worked closely with the PACER staff in our training sessions, contributing much. In the last semester, (January, 1977), four out of five classes were cancelled. One at Dixie Hollins continued with fourteen people, but the probability is that it is also cancelled at this time.

Due to cold weather this winter and due to lack of baby-sitting facilities, attendance at all classes was poor. The Adult Home Economics Department has committed teachers and slots to these classes continuing, but success depends very much on the teacher. The probability is that, they too, like other PACER components will cancel out.

Perhaps approaching a TV station and developing a half-hour child skills program might be the answer. Child care is the biggest obstacle to parents' attending classes. The other factor is that agency personnel must recommend classes and help the clients to see the value in them. Transportation is a problem also. The agencies did not respond and people who could have profitted from the classes were not informed. Judges could court order people to classes, but, to date, this has not happened.

APPENDIX H

Research

RESEARCH AND EVALUATION COMPONENT -

The PACER Research and Evaluation Component was designed to monitor the development and ongoing progress of the various other components of the project. The core indicators for overall evaluation were to be:

1. Number of validated instances of child abuse
2. Number of children successfully returned to families after validation of child abuse;
   a. Number of children again abused after return to their families
   b. Length of separation of families

Other general data which was to be collected for possible use for research and evaluation purposes of various components included:

1. Completion dates of hiring project staff and making purchase of service arrangements
2. Profile of suspected abused children;
   a. Race
   b. Sex
   c. Age
   d. Types of abuse
   e. Alleged abusers
   f. Person making report
3. Profile of parent

It was also proposed originally to evaluate the PACER sub objectives, in terms of input and output data, as follow:

1. To improve case finding by special training of school, social service agency and other personnel who have frequent contact with Pinellas youth.

   Input Data
   A. Number of staff trained
   B. Number of hours of training provided

   Output Data
   A. Number of instances of suspected abuse reported by persons receiving PACER training
   B. Number of instances of validated abuse reported by persons receiving PACER training
   C. Number of parents referred to indicated resources by persons receiving PACER training
   D. Number of parents actually utilizing resources to which referred by PACER trained personnel.
   E. Core indicators as listed above

2. To improve case finding and care and treatment of both children and their parents by development of hospital-based interdisciplinary child trauma teams

   Input Data
   A. Number of hospitals served by child trauma teams
   B. Number of children assessed by each team

Output Data

A. Number of children seen by participating hospitals in emergency rooms
   1. Number of children diagnosed (and reported) abused, failure to thrive, accidents, other
   2. Number of children detained when abuse is suspected
B. Disposition of child reported suspect abuse: number returned home immediately without supervision, number returned home immediately with follow-up, number referred to substitute care facility by type (emergency shelter, foster home, relative, group home, other)
C. Core indicators as previously stated

3. To improve the data base regarding abused children at the hospital level so as to lessen the possibility of error regarding diagnosis.

Input Data

A. Implementation of Child Trauma Registry
   1. Number hospitals and private physicians participating

Output Data

A. Number of requests made to Information & Referral agency for Child Trauma Registry data
B. Number of diagnoses (both abuse and other) in which registry was consulted

4. To assess the cost of hospital care of abused children and their families

Input Data

A. Implementation of data-retrieval system
B. Implementation of Child Trauma Teams
C. Implementation of Child Trauma Registry

Output Data

A. Average number of days child diagnosed and reported as abused is cared for at the hospital
B. Average cost of caring for child diagnosed and reported as abused at the hospital

5. To offer abusing parents additional opportunities of treatment, thereby minimizing removal of children from the natural home

Input Data

A. Implementation of "parents anonymous" group

Output Data

A. Number of persons participating in parents anonymous
B. Number of parents interviewed out of maternity wards
C. Number of parents in maternity wards identified as high risk
D. Number of high risk parents participating in parents anonymous or other appropriate resources
E. Number of children reported abused from among high risk parents (maternity ward)
F. Core indicators as previously stated

6. To improve the overall data base regarding the subject of child abuse so as to facilitate improved prevention, detection, and treatment of the condition at the county and possibly state and national level

Input Data

A. Implementation of the information management system proposed in this section

Output Data

A. Development of new programs and techniques for preventing, identifying and treating child abuse in Pinellas County and possible replication of these techniques, in particular the replication of the child trauma registry and information management system

Once the entire staff of PACER had begun work and a preliminary assessment of the relationship between the sub objectives and community response was made, it was felt that a re-determination of the program goals should be made. Using both staff discussions and an exercise in the Delberg technique conducted by Berkeley Planning Associates (BPA), the following objectives (primary and secondary) were formulated with the interim and outcome indicators.

## EVALUATION OF REVISED GOALS AND OBJECTIVES OF PACER

Overall Goal:

PARENT AND CHILD EFFECTIVE RELATIONS PROJECT (PACER) is a preventive effort with the over-all goal of significantly reducing the true incidence of child abuse and neglect among Pinellas County families, and to do this by strengthening the ability of families to properly care for and nurture children. We recognize that this goal may be impacted by the current changes in socio-economic conditions and that project efforts may initially influence reporting rates in a spiraling manner.

> The overall goal reflects the preventive focus of the PACER project. The successful implementation of the 'interim' steps and the fulfillment of the 'outcome' goals of each of the five primary objectives and three secondary objectives will provide the necessary implementation of the over-all goal. As PACER proceeds with the development of each objective, the Pinellas County community should become more and more aware of the issue of child abuse and neglect.

Achievement of this goal is to be accomplished through pursuing the following objectives:

### PRIMARY OBJECTIVES

1. To provide educational programs and community information aimed at the public in general and at high risk groups in particular.

   INTERIM:

   a. Establishment of educational and community information programs (audio-visual materials, talks, seminars, brochures, etc.).

   b. Number of oral presentations given and written communications distributed on the nature of abuse and neglect.

   c. Amount of media coverage on the problem of abuse and neglect.

   d. Number of presentations to high risk groups.

   OUTCOME:

   a. Perception by community that understanding of abuse and neglect has improved (re: survey sampling).

b. Perception by community that the stigma attached to child abuse and neglect has been reduced (re: survey sampling).

c. Increase in reports from those people or institutions not now reporting.

d. Increase in self-referrals, e.g., before serious incident occurs.

2. To provide training programs for professionals and paraprofessionals for the purpose of increasing their knowledge of child abuse/neglect and of their professional responsibility.

INTERIM:

a. Implementation of training program.

b. Percentage (numbers) of professionals/paraprofessionals (pediatricians, radiologists, OBs, ERs, GPs, psychologists, psychiatrists, nurses (in OB, ER and pediatrics), teachers, school social workers, caseworkers, headstart personnel, law enforcement personnel, and others) trained in current preventive/treatment techniques in abuse/neglect as compared to those working in that area at that time.

c. Number of requests by professionals/paraprofessionals for further education and training.

d. Number of training programs receiving certification and/or accreditation for educational, health, and other personnel (Narrative).

OUTCOME:

a. Perception of professional/paraprofessional personnel that their knowledge has improved (Narrative-type feedback).

b. Involvement of professional/paraprofessional personnel in the abuse/neglect problem as reflected by:

(1) an increase in the number of referrals to treatment/preventive resources;

(2) number of follow-up inquiries (re: log-sheet);

(3) institutional changes re: child abuse/neglect, e.g., in-service programs ER procedures, school sessions, Legislature, DFS, pre-natal classes, day-care, Police Academy, etc.;

(4) increased health personnel involvement in community endeavors, e.g., educational activities, team efforts, etc.

(a) Changes in activities.

3. To enhance case finding and treatment planning for both children and their families through the development of child trauma teams, a law intern program, and a child trauma medical registry.

SHORT-TERM

INTERIM:

a. Identification of public areas in implementation.

b. Initiation of legislative changes, if necessary, to provide for implementation.

c. Involvement of health personnel hopefully in implementation of CTT as seen by number participating and changes in the procedures and policies of professional associations and health institutions.

d. Clear delineation of agency roles in the legal procedures involved in child abuse/neglect cases.

OUTCOME:

a. Perception of health personnel regarding value and use of Child Trauma Teams (CTT), after the establishment of CTTs (Narrative).

b. Changes in policies and procedures of agencies; for example: agreements between JWB, DFS, and the State Attorney's office.

LONG-TERM

INTERIM:

a. Number of hospitals served by CTT.

b. Number of children assessed by CTT.

c. Perception of health personnel of need for child trauma medical registry as a result of work by CTT (Narrative).

d. Establishment of child trauma medical registry.

e. Number of reports in registry.

f. Number of hospitals and private physicians reporting to registry.

g. Number of consultations of registry by county physicians.

h. Number of consultations of registry by out-of-county physicians.

i. Perception by agencies involved of the effectiveness of law-intern program.

OUTCOME:

a. Number of children seen by participating hospitals in Emergency Rooms (ERs).

   (1) Number of children diagnosed (and reported) abused, neglected, accidents, other.

   (2) Number of children admitted when abuse/neglect is suspected.

   (3) Before vs. after figures re: children in ERs (after determining feasibility).

b. Disposition of child reported suspected abuse/neglect; number returned home immediately without supervision, number returned home immediately with follow-up, number referred to substitute care facility (by type: emergency shelter, foster home, group home, other).

c. Monitor procedures of treatment planning.

d. Perception by hospitals and private physicians of the usefulness of the registry for medical diagnosis.

4. To develop new treatment services for identified abusers/neglecters and potential parents at risk, including Parents Anonymous and Parent Aides.

INTERIM:

a. Completion of an abuse/neglect needs assessment survey, showing the delineation of services available and unavailable, including number of clients served by the different agencies, public and private (this could possibly be done by a mailing to all agencies re: services they provide).

b. Establishment of needed services, such as Parents Anonymous, Parent Aides, child management classes, crisis nurseries, services for new mothers, and other specialized groups.

c. Monitor number of people served in these new programs as compared to total requests for services.

OUTCOME:

a. Determine effect of new services upon client families.

(1) Narrative, aggregate evaluation of Parents Anonymous groups by the group sponsors.

(2) Monitoring of Parent Aide instruments (BPA).

(3) General narrative evaluation (from questionnaire) of child management classes re: number in attendance, length of stay in program, participation in class, etc.

(4) Narrative feedback from sponsors of other resources which may be developed.

(5) Overall, general narrative evaluation by PACER staff.

b. Perception by clients who received 'new' services that they are functioning at an improved level; i.e., a general narrative reflecting client feedback.

5. To initiate a procedure for early identification of high risk families and a method for follow-up and referral to service resources.

INTERIM:

a. Establishment of program of maternity ward monitoring. (This is a long-term goal based upon the perception of the health community of the usefulness of this program and identifying and treating high risk parents. The mother-infant interaction behavioral check-list would be used in this identification and then packets of information concerning services and resources available would be given to the parents with later follow-up).

OUTCOME:

a. Number of maternity ward parents utilizing resources to which referred.

## SECONDARY OBJECTIVES

1. To provide the impetus for a coordinated community system of combined preventive and corrective efforts aimed at minimizing child abuse and neglect in Pinellas County.

   INTERIM:

   a. Clear delineation of respective agency roles in the abuse/neglect system (per needs assessment survey).

      (1) Number and kinds of standarized procedures and instruments used by the agencies dealing with abuse/neglect.

   b. A method for monitoring the number and kinds of contacts and referrals of agencies offering services for abuse/neglect (based on findings of Item a.).

   OUTCOME:

   a. Decrease in the number of inappropriate referrals and/or cases never referred due to lack of available services.

   b. Increase in the total number of referrals between agencies.

   c. Increase in the percentage of referrals followed up by agencies dealing with abuse/neglect. (Items a, b, and c depend on the availability of information from case records.)

   d. Addition of new services in the community to fill existing gaps.

   e. Elimination of duplication of effort and services (Narrative evaluation).

   f. Increase in the allocation of total resources for abuse/neglect (budgetary information re: needs assessment survey).

2. To improve the overall data base regarding the subject of child abuse so as to facilitate improved prevention, detection and treatment of the condition at the county, state and possibly national level.

   INTERIM:

   a. Implementation of information management system reflecting data from:

      (1) Central medical registry;

      (2) Profile of parent;

      (3) Hospital costs;

      (4) PACER Project report (Narrative):

         (a) Parents Anonymous;

         (b) Parent Aide program;

         (c) child management classes;

         (d) Child Trauma Team(s);

(c) Maternity Ward monitoring;

(f) Law Intern program;

(g) Additional new programs initiated.

OUTCOME:

a. Development of new programs and techniques for preventing, identifying and treating child abuse/neglect in Pinellas County and possible replication of these techniques, in particular the replication of the child trauma registry and information management system.

3. To assess the cost of hospital care of abused children and their families both before and after the establishment of child trauma teams.

INTERIM:

a. Implementation of data-retrieval system.

b. Monitor data from Child Trauma Team(s).

c. Monitor data from Child Trauma Medical Registry.

OUTCOME:

a. Average number of days child diagnosed and reported as abused is cared for at the hospital.

b. Average cost of caring for child diagnosed and reported as abused at the hospital.

-----This is a long-range goal that is based upon the implementation of the Child Trauma Teams, Child Trauma Medical Registry, and the perception and willingness of health personnel to make such information available to JWB. The results of such information will be compared to the findings of the Newberger project based in Boston.

After further culling and refining, with additional input from Kathy Armstrong, the BPA liaison, the following goals, objectives (primary and secondary), and steps and outcomes were developed as a final basis for the evaluation of the PACER program goals.

Overall Goal Statement

Parent and Child Effective Relations Project (PACER) is a preventive effort with the overall goal of significantly reducing the true incidence of child abuse and neglect among Pinellas County families, and to do this by strengthening the ability of families to properly care for and nurture children. We recognize that this goal may be impacted by the current changes in socio-economic conditions and that project efforts may initially influence reporting rates in a spiraling manner. Achievement of this goal is to be accomplished through pursuing the following objectives:

Primary Objectives

I. To provide educational programs and community information aimed at the public in general and at high risk groups in particular.

II. To provide training programs for professionals and paraprofessionals for the purpose of increasing their knowledge of child abuse/neglect and of their professional responsibili

III. To enhance case finding and treatment planning for both children and their families through the development of child trauma teams, a law intern program, and a child trauma medical registry.

IV. To develop new treatment services for identified abusers/neglecters and potential parents at risk, including Parents Anonymous and Parent Aides.

V. To initiate a procedure for early identification of high risk families and a method for follow-up and referral to service resources.

Secondary Objectives

I. To provide the impetus for a coordinated community system of combined preventive and corrective efforts aimed at minimizing child abuse and neglect in Pinellas County.

II. To improve the overall data base regarding the subject of child abuse so as to facilitate improved prevention, detection and treatment of the condition at the county, state, and possibly national level.

III. To assess the cost of hospital care of abused children and their families both before and after the establishment of child trauma teams.

Following are the step and outcome measurements used to evaluate each of the objectives, both primary and secondary:

I. Has PACER provided educational programs and community information aimed at the public in general and at high risk groups in particular?

A. Steps

1. Establishment of an education and community information program.
   a. Have plans been drawn up for education of targeted groups?
      ____ Describe the procedures:

   b. How many groups have been targeted for concentrated educational efforts?
      ____ Name the targeted groups:

2. Education and community information presentations and media coverage
   a. How many education/training sessions have been held with the targeted groups? Expected _____ Actual _____
      Name the audience and number of sessions held per targeted group:

   b. How many people (minus media) were provided with education and information? Expected _____ Actual _____ Describe the number of people per targeted group:

   c. What has been the amount of media coverage on the problem of abuse/neglect? Expected _____ Actual _____ Describe the scope of the coverage:

B. Outcomes

1. Perception by the community that their understanding of the problem of abuse/neglect has improved.
   --What proportion of the community sampled perceive that their understanding of abuse/neglect has improved? _____ Describe the method of assessment and the results:

2. Increased reporting from those people or institutions not previously reporting.
   --What has been the percentage increase in reports from previously non-reporting sources? _____ Name the referral sources:

3. More self-referrals before serious incidents occur.
   a. What is the ratio of the current percentage of self-referrals to the percentage before PACER began? _____

   b. What is the ratio of the current percentage of self-referrals made before a serious incident occurred to the initial percentage? _____

II. Has PACER provided training programs for professionals and paraprofessionals to increase their knowledge of child abuse/neglect and of their professional responsibilities?

A. Steps

1. Provision of training to professionals/paraprofessionals
   a. How many training sessions have been held with targeted groups? Name the audiences and the number of sessions per group:
   Expected: _____ Actuals: _____

   b. What percentage of professionals/paraprofessionals in the following categories have received training as compared to those in that area at the current time?

| | Expected | Actual |
|---|---|---|
| Pediatricians: | | |
| Radiologists: | | |
| OB's: | | |
| Emergency Room Physicians: | | |
| General Practitioners: | | |
| Psychologists: | | |
| Psychiatrists: | | |
| Nurses: | | |
| Teachers: | | |
| School Social Workers: | | |
| Caseworkers: | | |
| Head Start Personnel: | | |
| Police Academy: | | |
| Day Care Centers: | | |
| Child Guidance Clinic: | | |
| Public Health Department: | | |
| Family Counseling Center: | | |
| Adult Mental Health: | | |
| Project Playpen: | | |
| Day Care Homes: | | |
| Other Health Agency Personnel: | | |
| Other Social Service Personnel: | | |
| Other: | | |

2. Filling requests for further training or education by professionals/paraprofessionals
   a. What percentage of those already trained request follow-up training or education? _____ Name these groups: _____

   b. What percentage of requests for follow-up training are filled? _____

3. Certification or accreditation of the PACER-sponsored training programs.
   --How many training programs received certification/accreditation?
   Expected _____ Actual _____ Name the programs: _____

B. Outcomes

1. Perception by professionals/paraprofessionals that their knowledge has improved.
   --What proportion of professionals/paraprofessionals who have received training perceived that their knowledge has improved? _____
   Describe the means of assessment and the results: _____

2. Increase in the number of referrals and follow-up inquiries from professionals/paraprofessionals to prevention/treatment resources.
   --What is the ratio of the current percentage of referrals and follow-up inquiries made by professionals/paraprofessionals to the percentage before PACER began? _____/_____
   referrals / follow-up inquiries

3. Institutional changes accrued in the community which might be attributed to the education of professionals/paraprofessionals by PACER.
   a. Has child abuse/neglect education been added to any on-going in-service programs? ____ Name the programs: _____

   b. Have any new procedures of detection of abuse/neglect been introduced into hospital settings? Describe the procedures: _____

   c. What changes in the Florida law related to abuse/neglect have occurred due in part to PACER's efforts?

   d. How many new services for abuse/neglect have been implemented by other community agencies? _____ Describe the services and agencies involved.
   Expected:
   Actual:

   e. What other agencies/professionals have introduced changes in their practices with regard to the prevention/identification/reporting/treatment of abuse or neglect? Describe the changes:

4. More involvement of health personnel in the abuse/neglect problem.
   --What new activities have health personnel undertaken with regard to the problem (e.g., educational presentations, team efforts, development of services, etc.)? Describe:
   Expected:
   Actual:

III. Has case finding and treatment planning for children and families been enhanced through the development of child trauma teams, a law intern program and a child trauma registry?

A. Steps

1. Identification of problem areas in implementation of the above components.
   a. What problems and solutions were discovered in the attempts to implement these components? Explain:

   b. What legislative changes were necessary to implement these components? Explain:

2. Involvement of health professionals in the implementation of the Child Trauma Team.
   a. What mechanisms were established for involving health personnel in the development of the Trauma Team? Describe:

b. What procedural or policy changes of professional associations or health institutions did this involvement effect? Explain:

3. Service of hospitals by Child Trauma Teams.
--How many hospitals have developed Child Trauma Teams, or been served by a roving Trauma Team as a result of PACER effort?
Expected _____ Actual _____
Name the hospitals:

4. SES cases handled by Legal Interns.
--How many cases per year have been handled for SES?
Expected _____ Actual _____

B. Outcomes

1. Improved treatment planning.
--What is the ratio of the percentage of abuse/neglect cases seen in hospitals with Trauma Teams that have the dispositions determined, to the percentage of similar dispositions in non-Trauma Team hospitals?

2. Perception of usefulness of the Child Trauma Teams.
a. What proportion of health personnel surveyed perceive that the Child Trauma Teams have been useful? _____ Describe the results of the survey:

b. What proportion of non-health personnel surveyed (e.g. SES) perceive that Child Trauma Teams have been useful? _____ Describe the results:

3. Perception of SES workers that the Legal Interns are helpful.
--What percentage of SES workers find the Interns helpful? _____
Describe the method of assessment and the results:

4. Acceptance by court of recommendations by Interns.
--In what proportion of SES cases handled by Interns were recommendations upheld in court? _____

IV. Have new treatment services for identified abusers/neglecters and parents at risk, including Parents Anonymous and Parent Aides, been developed?

A. Steps

1. Understanding by project of what services are available in the county and where gaps or duplication of services exist.
a. Has the project conducted a needs assessment survey? _____
Explain the method:

b. How many people are currently receiving services per year from each agency included in the survey?

c. What are the gaps in the service system?

d. What are the system's functional duplications?

2. Implementation of new services in the county.
a. How many new treatment services have been implemented due in part to PACER involvement:
Expected:
Actual:

b. How many people have been served per new program?
Expected:
Actual:

B. Outcomes

1. Effective service from Parents Anonymous groups.
   a. What is the perception of the group sponsors regarding the overall effectiveness of the Parents Anonymous groups?
   Describe:

   b. What is the perception of the group members regarding the effectiveness of the P.A. groups? Describe:

   c. How long, on the average, do members regularly participate in Parents Anonymous? _____

2. Reduction of abusive/neglectful behavior or potential behavior on the part of clients who received services from Parent Aides.
   a. What is the reduction in the proportion of clients who re-abused/neglected while receiving services from Parent Aides? _____

   b. What proportion of clients who received services from Parent Aides reduced their potential for re-abuse/neglect based on the Parent Aides' (or SES workers') judgement? _____

   c. What proportion of clients who received services from Parent Aides improved their functioning on the thirteen BPA functioning indicators? ____

   d. What proportion of clients who had received services from Parent Aides continued to demonstrate a low potential for future abuse/neglect after follow-up? _____

3. Effective services by the Child Management Classes.
   a. What was the attendance rate for the classes?
   Expected _____
   Actual _____

   b. What percentage of attendees regularly participated while in class?
   Expected _____ Actual _____

   c. How many attendees perceived that the classes were useful? _____
   Describe the method of evaluating this:

4. Effective intervention by means of other new services.
   a. What proportion of service sponsors perceive the new services to be effective? _____ Describe the opinions of the sponsors:

   b. For each new service developed, how many clients of those services perceived that their functioning has improved? _____
   Describe the method of evaluating effectiveness and the results:

V. Has a procedure for early identification of high risk families and a method for follow-up and referral to service resources been developed?

A. Steps

1. Development of a process for identification of high risk families.
   a. Has a maternity ward monitoring program been developed? _____

b. Have any other programs for identifying high risk families been developed? _____ Describe:

B. Outcomes

1. Identification of high risk families.
   a. What proportion of screened families were identified as high risk? ____
   b. What was the disposition of those families identified? Explain:
   c. What proportion of families identified as high risk and referred for services used the resources to which they were referred? _____

2. The percentage of the total number of new babies contacted by NPIS interviewers.
   Target number _____ Actual number _____

3. The total number of interviewers involved with the project component.
   --The average number of interviewers per month:
   Target _____ Actual _____

4. Some assessment of the interest expressed by the agencies in the information packet, as well as the Protective Service Agency and hospitals. (What do they see as valuable? What needs are still unmet; general impressions.)

5. Some assessment of follow through. What proportion of cases referred to other agencies:
   a. actually contacted services?
   b. used the services?

6. Process assessment of the evolution of NPIS component, "Birth of an Idea".

Secondary Objectives

I. Has PACER provided the impetus for a coordinated community system of combined preventive and corrective efforts aimed at minimizing child abuse and neglect in Pinellas County?

A. Steps

1. Clearly delineating agency roles in the abuse/neglect system.
   a. Has a needs assessment survey been completed? _____
      Explain how it was carried out:
   b. What are the system functions that are duplicative?
   c. What services are missing in the Pinellas County system?

2. Development of standardized procedures and/or instruments for use in dealing with abuse/neglect cases.
   a. What standardized procedures and instruments have been developed? Describe:
   b. How many agencies in the county are using standardized procedures and instruments? Expected _____ Actual _____

3. Establishment of procedural protocols between key service agencies.
   --How many protocols have been drawn up since PACER began?
   Expected _____ Actual ____

4. Participation by project staff in community coordination activities.
   --How many times have PACER staff attended meetings for the purpose of coordinating community-wide child abuse/neglect activities?

B. Outcomes

1. Perception by personnel in abuse/neglect related agencies that the community system is better coordinated.
   --What percentage of such personnel perceive the system to be better coordinated than before PACER began? _____ Describe the method of assessing this opinion:

2. An increase in the total number of interagency referrals.
   a. What proportion of community-wide cases involve interagency referrals? Expected _____ Actual _____

   b. What was the increase in the volume of interagency referrals since implementation of the new coordination procedures? _____

3. An increase in the percentage of referrals that receive follow-up by the referring agency.
   --What is the increase in percentage of referrals that are followed-up by the referring agency since coordination procedures went into effect? Expected _____ Actual _____

4. New services implemented in the community to fill existing gaps.
   a. What new services have been implemented?

   b. What new services identified as necessary by the needs assessment survey have been implemented?

5. Elimination of duplication of efforts/services.
   --What are the duplication of efforts/services that have been eliminated or reduced, at least in part through PACER activities?

6. An increase in the allocation of total resources for abuse/neglect.
   --How much new money has been allocated to abuse/neglect since PACER began? _____ Describe the dimensions of the new allocations:

II. Has the overall data base regarding child abuse been improved so as to facilitate improved prevention, detection and treatment at the county, state and national levels?

A. Steps

1. Development of a management information system.
   a. What information is contained in the management information system? Explain the type of information, how it is collected, frequency of collection, data processing or tabulation system, and frequency of reports:

   b. How is this information used by involved agencies for management purposes? Explain:

   c. To what other use is the data being put? Explain:

B. Outcomes

1. Perception by agencies/personnel that the management information system is useful.
   --What proportion of agencies/personnel using the system find it useful? _____ Describe the means by which this assessment was made and the results:

2. Development of new programs and/or techniques for preventing, identifying and treating child abuse due to implementation of the system.
--What new programs and/or techniques have been developed that were, in part, influenced by the information available from the management information system? Describe:

3. Replication of the management information system elsewhere.
--What other Florida counties or any communities in the country have expressed interest in developing an information system based on the PACER model?

III. Have the costs of hospital care of abused children and their families before and after the establishment of the child trauma team been assessed?

A. Steps
1. Establishment of data retrieval system.
--What is the nature of the data retrieval system developed? Explain the participation of hospitals, what information is being collected, what the sources of data are, what the data processing and analysis procedures are:

B. Outcomes
1. Knowledge of length of stay of hospitalized abused children in Pinellas County.
--What is the comparative average number of days a child diagnosed and reported abused is hospitalized before and after implementation of the Trauma Team?

_____

2. Knowledge of the cost of caring for abused/neglected children who are hospitalized.
--What is the comparative average cost per child of hospitalization resulting from abuse before and after implementation of the Trauma Team? _____

3. Addition of cost data for the child abuse field in general.
--How do PACER findings compare with the study at Children's Hospital, Boston? Explain the differences, if any, and the causes of the differences:

4. Changes in procedures and operations resulting from the cost study.
--What changes have been made in hospital procedures and operation of the trauma teams? Describe:

General Comments:

Once the project goals and evaluation means were established, the determination was then made as to how to gather the information. After several meetings and discussions, staff members agreed to provide the information required to evaluate their individual components. All other material would be gathered by the Planning Technician with emphasis on the results of the SES Protective Services case sampling and the Needs Assessment Survey. Information and data would also be collected by Berkeley Planning Associates, primarily through their community interviews and use of their coordination/education log forms.

Secondary Objectives II and III, pertaining to the management information system and the hospital costs, were determined to be infeasible to evaluate. The Research and Evaluation unit of the Juvenile Welfare Board of Pinellas County is working on a community-wide data base system, but concentrating on all services to children, not just child abuse and neglect. This unit would also be primarily responsible for studying hospital cost studies, if and when such a study becomes practical.

The research component of PACER also developed several sets of questionnaires and forms to be used in evaluating the effectiveness of the training and education programs. These

questionnaires were primarily used for evaluating and updating the training efforts. No formal questionnaire results were tabulated as the diversity of the target population was such as to preclude the use of an attitudinal change survey.

Two major research projects were initiated and carried through by the PACER research component. The first of these was a case smpling of Protective Services cases, and the second was a Needs Assessment survey of child-serving agencies in Pinellas County concerning their awareness of the child abuse/neglect system in the county. On the following pages are the results and narratives of these two surveys.

## SES PROTECTIVE SERVICES CASE SAMPLING

The PACER project, in connection with Berkeley Planning Associates, the national evaluators for the eleven federal demonstration projects in child abuse and neglect, conducted a case sampling of child abuse cases in Pinellas County.

The sampling - 405 cases out of a total of 3,777 assigned cases - covered the period from October/1971 (when the state toll-free child abuse Hotline began) to June 30, 1975. These 405 cases represented 10.7% of the total cases involved. The "assigned" classification referred to those cases where a social worker made a home or field visit during the investigation of the report. In other words, the worker physically left his office to conduct the investigation, rather than rely on a form letter or telephone call for his/her facts. There were 70 cases from the sample period October/1971 - June 30, 1972; 108 cases from July 1, 1972 - June 30, 1973; 117 cases from July 1, 1973 - June 30, 1974; and 110 cases from July 1, 1974 to June 30, 1975.

After an initial sampling of 94 cases in the spring of 1976, the final sample questionnaire was developed and the case sampling begun. Of the original cases chosen for sampling, some 40 odd cases (roughly 10%) were "lost" and could not be located. New cases were substituted for these, in the interest of time.

Following is an initial tabulation of the results of the SES survey. Berkeley Planning Associates will be incorporating the results in their Community Systems report. Further tabulation and analysis of this study will be conducted by the Research and Evaluation Unit of the Juvenile Welfare Board of Pinellas County.

PROTECTIVE SERVICES CASE SAMPLING TABULATION

| | ITEM | NUMERICAL RESPONSE | PERCENTAGE |
|---|---|---|---|
| 1. | BLANK | 0 | ----- |
| 2. | BLANK | 0 | ----- |
| 3. | Year Abuse/Neglect Reported: | | |
| | a. Oct. 1971-June 30, 1972 | 70 | 17.3% |
| | b. July 1, 1972-June 30, 1973 | 108 | 26.6% |
| | c. July 1, 1973-June 30, 1974 | 117 | 28.9% |
| | d. July 1, 1974-June 30, 1975 | 110 | 27.2% |
| Age of child: | | | |
| 4. | a. Less than one year | 35 | 8.6% |
| | b. 1 year | 32 | 7.8% |
| | c. 2 years | 30 | 7.3% |
| | d. 3 years | 33 | 8.1% |
| | e. 4 years | 16 | 3.9% |
| 5. | a. 5 years | 26 | 6.4% |
| | b. 6 years | 19 | 4.6% |
| | c. 7 years | 15 | 3.7% |
| | d. 8 years | 19 | 4.6% |
| | e. 9 years | 19 | 4.6% |
| 6. | a. 10 years | 17 | 4.2% |
| | b. 11 years | 8 | 2.0% |
| | c. 12 years | 31 | 7.6% |
| | d. 13 years | 27 | 6.6% |
| | e. 14 years | 30 | 7.3% |
| 7. | a. 15 years | 25 | 6.1% |
| | b. 16 years | 20 | 4.9% |
| | c. 17 years | 5 | 1.2% |
| | d. Unknown | 2 | .5% |
| 8. | Race of child: | | |
| | a. White | 323 | 80.8% |
| | b. Black | 75 | 18.7% |
| | c. American Indian | 0 | ----- |
| | d. Oriental | 0 | ----- |
| | e. Spanish Surname | 2 | .5% |
| 9. | Sex of child: | | |
| | a. Male | 235 | 57.9% |
| | B. Female | 171 | 42.1% |

| ITEM | | NUMERICAL RESPONSE | PERCENTAGE |
|---|---|---|---|
| 10. | Number of other children in the family: | | |
| | a. None | 114 | 28.4% |
| | b. One | 110 | 27.4% |
| | c. Two | 72 | 17.9% |
| | d. Three | 56 | 13.9% |
| | e. Four+ | 50 | 12.4% |
| 11. | Number of other children in family reported a/n: | | |
| | a. None | 200 | 54.8% |
| | b. One | 67 | 18.3% |
| | c. Two | 44 | 12.1% |
| | d. Three | 31 | 8.5% |
| | e. Four+ | 23 | 6.3% |
| | Type of Abuse(Primary child): | | |
| 12. | a. Dead on Arrival | 2 | 1.0% |
| | b. Death due to injuries | 0 | ----- |
| | c. Permanent Injury | 2 | 1.0% |
| | d. Sexual Abuse | 22 | 11.1% |
| | e. Beatings | 94 | 47.5% |
| 13. | a. Skull Fracture | 4 | 2.0% |
| | b. Broken Bones | 6 | 3.0% |
| | c. Cuts | 6 | 3.0% |
| | d. Burns | 12 | 6.1% |
| | e. Bruises | 50 | 25.3% |
| | Type of Neglect(Primary child): | | |
| 14. | a. Malnutrition | 33 | 7.5% |
| | b. Medical Neglect | 36 | 8.2% |
| | c. Disorganized Family Life | 173 | 39.2% |
| | d. Abandoned | 14 | 3.2% |
| | e. Runaway | 28 | 6.3% |
| 15. | a. Unattended | 113 | 25.6% |
| | b. School Problems | 12 | 2.7% |
| | c. Other | 18 | 4.1% |
| | d. Unknown | 0 | ----- |
| | e. Custody Dispute | 14 | 3.2% |
| | Person reporting Abuse/Neglect: | | |
| 16. | a. Doctor | 7 | 1.6% |
| | b. Nurse | 8 | 1.9% |
| | c. Hospital | 18 | 4.2% |
| | d. Police | 79 | 18.6% |
| | e. Lawyer | 3 | .7% |

| ITEM | | | NUMERICAL RESPONSE | PERCENTAGE |
|---|---|---|---|---|
| 17. | a. | Court | 7 | 1.6% |
| | b. | Day Care Center | 2 | .5% |
| | c. | School | 33 | 7.8% |
| | d. | Division of Youth Services(DYS) | 18 | 4.2% |
| | e. | Protective Services | 4 | .9% |
| 18. | a. | Clergy | 3 | .7% |
| | b. | Institution | 0 | ----- |
| | c. | Relative | 39 | 9.2% |
| | d. | Spouse | 18 | 4.2% |
| | e. | Sibling | 4 | .9% |
| 19. | a. | Neighbor | 106 | 24.9% |
| | b. | Anonymous | 33 | 7.8% |
| | c. | Self Referral | 12 | 2.[illegible] |
| | d. | Unknown | 3 | .7% |
| | e. | Other | 22 | 5.2% |
| Alleged Abuser: | | | | |
| 20. | a. | Mother | 216 | 48.7% |
| | b. | Father | 76 | 17.1% |
| | c. | Both parents | 68 | 15.3% |
| | d. | Aunt | 2 | .5% |
| | e. | Uncle | 4 | .9% |
| 21. | a. | Grandfather | 2 | .5% |
| | b. | Grandmother | 4 | .9% |
| | c. | Grandparents | 4 | .9% |
| | d. | Step-mother | 6 | 1.4% |
| | e. | Step-father | 30 | 6.8% |
| 22. | a. | Foster Mother | 1 | .2% |
| | b. | Foster Father | 2 | .5% |
| | c. | Babysitter | 4 | .9% |
| | d. | Boyfriend | 18 | 4.1% |
| | e. | Neighbor | 1 | .2% |
| 23. | a. | Girlfriend | 1 | .2% |
| | b. | Other | 3 | .7% |
| | c. | Unknown | 1 | .2% |
| 24. | Race of Abuser: | | | |
| | a. | White | 326 | 81.9% |
| | b. | Black | 71 | 17.8% |
| | c. | American Indian | 0 | ----- |
| | d. | Oriental | 0 | ----- |
| | e. | Spanish Surname | 1 | .3% |

| ITEM | | NUMERICAL RESPONSE | PERCENTAGE |
|---|---|---|---|
| 25. | Length Case Closed: | | |
| | a. Less than 6 months | 222 | 55.1% |
| | b. 6-12 months | 25 | 6.2% |
| | c. Greater than one year | 143 | 35.5% |
| | d. Open | 13 | 3.2% |
| 26. | Length child placed in Institution: | | |
| | a. 1-3 months | 14 | 66.6% |
| | b. 3-6 months | 1 | 4.8% |
| | c. 6-9 months | 5 | 23.8% |
| | d. 9-12 months | 1 | 4.8% |
| | e. Greater than one year | 0 | ----- |
| 27. | Length child placed in Emergency Shelter: | | |
| | a. 1-7 days | 29 | 59.2% |
| | b. 8-14 days | 6 | 12.2% |
| | c. Greater than 14 days | 14 | 28.6% |
| 28. | Length child placed with Relative: | | |
| | a. 1-3 months | 13 | 56.5% |
| | b. 3-6 months | 1 | 4.3% |
| | c. 6-9 months | 2 | 8.7% |
| | d. 9-12 months | 2 | 8.7% |
| | e. Greater than one year | 5 | 21.7% |
| 29. | Length child placed in Foster Care: | | |
| | a. Under 3 months | 6 | 20.0% |
| | b. 3-6 months | 5 | 16.7% |
| | c. 6-9 months | 4 | 13.3% |
| | d. 9-12 months | 4 | 13.3% |
| | e. Greater than one year | 11 | 36.7% |
| 30. | Child returned home from: | | |
| | a. Institution | 9 | 14.1% |
| | b. Emergency Shelter | 34 | 53.1% |
| | c. Relative | 9 | 14.1% |
| | d. Foster Care | 10 | 15.6% |
| | e. Other | 2 | 3.1% |
| | Referral by Protective Services to: | | |
| 31. | a. Division of Youth Services | 17 | 4.0% |
| | b. School | 19 | 4.4% |
| | c. Juvenile Services Program | 0 | ----- |
| | d. Child & Family Comprehensive Mental Health | 30 | 7.0% |
| | e. Eckerd Camps | 7 | 1.6% |

| ITEM | | | NUMERICAL RESPONSE | PERCENTAGE |
|---|---|---|---|---|
| 32. | a. | Private | 10 | 2.3% |
| | b. | Other SES | 24 | 5.6% |
| | c. | Family Counseling Center | 9 | 2.1% |
| | d. | Other | 48 | 11.2% |
| | e. | No Referral | 264 | 61.7% |
| 33. | Number of Hearings Held: | | | |
| | a. | None | 292 | 75.4% |
| | b. | One | 34 | 8.8% |
| | c. | Two | 42 | 10.9% |
| | d. | Three | 10 | 2.6% |
| | e. | Four+ | 9 | 2.3% |
| Disposition of Case(Preliminary Hearings): | | | | |
| 34. | a. | Removal to Emergency Shelter | 27 | 27.0% |
| | b. | Protective Services Accepted: Child at home | 13 | 13.0% |
| | c. | Court-oredered Supervision: Child at home | 16 | 16.0% |
| | d. | Temporary, voluntary placement of child | 2 | 2.0% |
| | e. | Temporary, court-ordered placement of child | 23 | 23.0% |
| 35. | a. | Child returned home | 13 | 13.0% |
| | b. | Consent to adoption | 1 | 1.0% |
| | c. | Criminal action against abuser | 5 | 5.0% |
| | d. | Waiting further action | 0 | ----- |
| Disposition of Case(Final Hearing): | | | | |
| 36. | a. | Permanent Removal of child | 28 | 26.9% |
| | b. | Protective Services Accepted: Child at home | 4 | 3.8% |
| | c. | Court-ordered Supervision: Child at home | 16 | 15.4% |
| | d. | Temporary, voluntary placement of child | 1 | 1.0% |
| | e. | Temporary, court-ordered placement of child | 11 | 10.6% |
| 37. | a. | Child returned home | 34 | 32.7% |
| | b. | Consent to Adoption | 1 | 1.0% |
| | c. | Criminal action against abuser | 3 | 2.9% |
| | d. | Waiting further action | 2 | 1.9% |
| | e. | Custody dispute settled | 4 | 3.8% |
| 38. | Conditions applicable to family: | | | |
| | a. | Alcohol usage problems | 83 | 33.3% |
| | b. | Drug usage problems | 41 | 16.5% |
| | c. | Mental problems | 74 | 29.7% |
| | d. | Physical problems | 51 | 20.5% |

| ITEM | NUMERICAL RESPONSE | PERCENTAGE |
|---|---|---|
| 39. Was child: | | |
| a. Apprehended? | 13 | 21.3% |
| b. Detained? | 14 | 23.0% |
| c. Runaway? | 34 | 55.7% |
| 40. Is family involved in custody?: | | |
| a. Yes | 59 | 15.0% |
| b. No | 302 | 76.6% |
| c. Unknown | 33 | 8.4% |
| 41. Is religion significant in the case?: | | |
| a. Yes | 14 | 3.5% |
| b. No | 185 | 46.3% |
| c. Unknown | 201 | 50.2% |
| 42. Has family moved to the county in the last six months?: | | |
| a. Yes | 45 | 11.3% |
| b. No | 222 | 55.8% |
| c. Unknown | 131 | 32.9% |
| 43. Is abused child living with natural parents?: | | |
| a. Natural mother | 213 | 52.5% |
| b. Natural father | 36 | 8.9% |
| c. Both natural mother and father | 128 | 31.5% |
| d. Neither | 27 | 6.6% |
| e. Unknown | 2 | .5% |
| 44. Is the abused youngest child in family?: | | |
| a. Yes | 99 | 24.6% |
| b. No | 197 | 48.9% |
| c. Only child | 96 | 23.8% |
| d. Unknown | 8 | 2.0% |
| e. Twin | 3 | .7% |
| 45. Has abuser had military exerience?: | | |
| a. Yes | 16 | 4.0% |
| b. No | 45 | 11.1% |
| c. Unknown | 343 | 84.9% |
| 46. Does abuser have unusual work schedule?: | | |
| a. Yes | 64 | 15.8% |
| b. No | 157 | 38.8% |
| c. Unknown | 184 | 45.4% |

| ITEM | NUMERICAL RESPONSE | PERCENTAGE |
|---|---|---|
| 47. Was abuser once abused?: | | |
| a. Yes | 7 | 1.7% |
| b. No | 2 | .5% |
| c. Unknown | 391 | 97.8% |
| 48. Is Head of Household: | | |
| a. Unemployed? | 95 | 35.2% |
| b. Employed part-time? | 13 | 4.8% |
| c. Unknown | 162 | 60.0% |
| 49. Is family on public assistance?: | | |
| a. Yes | 115 | 29.3% |
| b. No | 190 | 48.3% |
| c. Unknown | 88 | 22.4% |
| 50. BLANK | | |
| 51. Was abuse/neglect report valid?: | | |
| a. Yes | 223 | 54.9% |
| b. No | 160 | 39.4% |
| c. Unknown | 23 | 5.7% |
| 52. Did legal counsel represent SES in court?: | | |
| a. Yes | 3 | 2.0% |
| b. No | 133 | 89.9% |
| c. Unknown | 12 | 8.1% |
| 53. Was child reported reabused or reneglected?: | | |
| a. Yes | 78 | 20.6% |
| b. No | 299 | 79.1% |
| c. Unknown | 1 | .3% |
| 54. Was report investigated?: | | |
| a. Yes | 73 | 86.9% |
| b. No | 11 | 13.1% |
| c. Unknown | 0 | ----- |
| 55. Was later abuse/neglect reported in family?: | | |
| a. Yes | 50 | 14.2% |
| b. No | 302 | 85.8% |
| c. Unknown | 0 | ----- |

| ITEM | | | NUMERICAL RESPONSE | PERCENTAGE |
|---|---|---|---|---|
| 56. | Number of later reports: | | | |
| | a. | One | 24 | 43.6% |
| | b. | Two | 20 | 36.4% |
| | c. | Three | 4 | 7.3% |
| | d. | Four | 5 | 9.1% |
| | e. | Five+ | 2 | 3.6% |
| 57. | Were reports investigated?: | | | |
| | a. | Yes | 50 | 92.6% |
| | b. | No | 3 | 5.6% |
| | c. | Unknown | 1 | 1.8% |
| 58. | Is investigation still continuing: | | | |
| | a. | Yes | 10 | 14.3% |
| | b. | No | 60 | 85.7% |
| | c. | Unknown | 0 | ----- |
| Case Worker: | | | | |
| 59. | a. | Osborne | 34 | 8.4% |
| | b. | Kilbride | 3 | .7% |
| | c. | Lewis | 6 | 1.5% |
| | d. | Schmidt | 37 | 9.1% |
| | e. | Mirabella | 43 | 10.6% |
| 60. | a. | Mitchell | 1 | .2% |
| | b. | Thornton | 10 | 2.5% |
| | c. | Fisher | 36 | 8.9% |
| | d. | Dillard | 71 | 17.5% |
| | e. | Farmer | 4 | 1.0% |
| 61. | a. | Christian | 8 | 2.0% |
| | b. | Sikes | 38 | 9.4% |
| | c. | Lovett | 10 | 2.5% |
| | d. | Ferguson | 20 | 4.9% |
| | e. | Simmons | 7 | 1.7% |
| 62. | a. | Haines | 1 | .2% |
| | b. | Godin | 2 | .5% |
| | c. | Hendrix | 2 | .5% |
| | d. | Rayner | 8 | 2.0% |
| | e. | Richards | 9 | 2.2% |
| 63. | a. | Belt | 3 | .7% |
| | b. | Phelps | 4 | 1.0% |
| | c. | Johnson | 7 | 1.7% |
| | d. | Sabin | 10 | 2.5% |
| | e. | Whitaker | 5 | 1.2% |

| | ITEM | NUMERICAL RESPONSE | PERCENTAGE |
|---|---|---|---|
| 64. | a. McLaughlin | 5 | 1.2% |
| | b. Ward | 2 | .5% |
| | c. Caffery | 1 | .2% |
| | d. Manuel | 2 | .5% |
| | e. Sheely | 0 | ----- |
| 65. | a. Hayden | 1 | .2% |
| | b. Zayzer | 6 | 1.5% |
| | c. Muckelroy | 4 | 1.0% |
| | d. Dalton | 1 | .2% |
| | e. Sargent | 1 | .2% |
| 66. | a. Gruenberg | 1 | .2% |
| | b. O. Smith | 1 | .2% |
| | c. Loomis | 2 | .5% |
| | d. Ruiz | 1 | .2% |

## NEEDS ASSESSMENT SURVEY

In the summer of 1976, the PACER staff conducted a Needs Assessment Survey of child-serving agencies in Pinellas County, to determine the knowledge and scope of the abuse/neglect system in the county. The staff compiled a list of those individuals and agencies that would be contacted.

Of the 135 individuals and agencies listed, it was decided that 46 would be contacted by mail, being asked to answer the questionnaire and send it back to PACER. The remaining 89 would also be contacted by mail, to be followed by an individual interview conducted by a PACER staff person. In both groups, the questions asked were the same.

Of the 46 individuals/agencies contacted in the non-interview group, 19 returned the questionnaire. Of the 89 individuals/agencies in the interview group, 53 interviews were held. (Often these interviews were with several people in the same agency or with one person representing several different units in one agency.) Of the interview group, a representative of all but one agency was conducted and interviewed.

The questionnaire was developed through the efforts of the Research and Evaluation Unit of Juvenile Welfare Board, Berkeley Planning Associates, and the PACER staff. Following is a copy of the questions and the preliminary tabulation of the responses. Further tabulation and analysis will be conducted by the Research and Evaluation Unit of the Juvenile Welfare Board.

# NEEDS ASSESSMENT SURVEY

Purpose: To assess services available to families with either actual or potential abuse/neglect problems; to determine gaps and duplications in the community abuse/neglect system; to identify possible areas of implementation of new services.

I. GENERAL QUESTIONS

1. Do you or does your agency provide some service to families with abuse/neglect problems?

2. What percentage of your total caseload is concerned with a/n cases?

3. What do you do with reports of a/n? How much time elapses between the report and the investigation?

4. How many a/n clients receive your services?

5. Are your a/n cases or clients increasing in number?

6. Do you do any follow-up on your terminated a/n cases? When?

7. Budget information.

II. SERVICES

1. Does your agency provide any of the following:

   a. Preventive services dealing with a/n?

   b. Outreach programs dealing with a/n?

   c. Community education and professional training activities in the field of a/n?

2. What services are provided to:

   a. Parents?

   b. Children?

   c. Families?

3. Which of these functions do you provide: identification, investigation, treatment planning, treatment services, referrals, placement, follow-up, shelter?

4. Are services structured for the convenience of the clients; e.g., hours, location, transportation, etc.?

5. Are services adequate to meet client needs or are there built-in problems: waiting lists, large caseloads, restrictions of any sort? If so, please describe these briefly.

6. How well publicized are your services? Are potential clients aware of the availibility and/or accessibility of your services?

III. COORDINATION

1. What other agencies do you primarily use as resources for a/n cases?

2. Do you have problems of coordinating your services with other agencies or does the a/n system allow for easy and ample coordination among agencies?

3. Are you involved in any specific procedure or interagency agreement to insure better coordination and treatment of a/n cases?

4. Is there a procedure for sharing information when more than one agency is providing services to the same client: re: question # 3?

5. Do you feel it is possible to 'lose' a client due to non-referral or inadequate referral? If so, how might this be corrected?

IV. OVERALL VIEW

1. Which agency do you perceive as the central one for handling a/n cases?

   b. Reporting cases?

   c. Investigating cases?

   d. Providing treatment?

2. Do you see the need for an interagency a/n task force/committee?

3. What 'gaps' do you see in the community a/n system?

4. What duplications do you see in the community a/n system?

5. Is the a/n system overloaded--are more cases being reported that it is possible to investigate?

6. What do you perceive as being the basic problems of the community a/n system? What are the basic strengths?

NEEDS ASSESSMENT SURVEY TABULATION

| ITEM | | NUMERICAL RESPONSE | PERCENTAGE |
|---|---|---|---|
| I. | GENERAL QUESTIONS | | |
| 1. | Caseload figures: | | |
| 1. | ABUSE: (a) 0-5% | 39 | 67.0% |
| | (b) 5-10% | 5 | 9.0% |
| | (c) 10-25% | 8 | 14.0% |
| | (d) 25-50% | 3 | 5.0% |
| | (e) 50-100% | 3 | 5.0% |
| 2. | NEGLECT: (a) 0-5% | 34 | 58.0% |
| | (b) 5-10% | 6 | 10.0% |
| | (c) 10-25% | 8 | 14.0% |
| | (d) 25-50% | 5 | 8.0% |
| | (e) 50-100% | 6 | 10.0% |
| 2. | Length of time between report and investigation: | | |
| 3. | (a) Less than one hour | 1 | 1.0% |
| | (b) 1-12 hours | 9 | 13.0% |
| | (c) 12-24 hours | 2 | 3.0% |
| | (d) 24-48 hours | 4 | 6.0% |
| | (e) 2-4 days | 1 | 1.0% |
| 4. | (a) 1-2 weeks | 1 | 1.0% |
| | (b) 2-4 weeks | 2 | 3.0% |
| | (c) forever | 1 | 1.0% |
| | (d) no investigation | 1 | 1.0% |
| | (e) no response | 26 | 36.0% |
| 5. | (d) varies | 13 | 18.0% |
| | (e) don't know | 11 | 15.0% |
| | Feedback from SES: | | |
| 5. | (a) Yes | 2 | 3.0% |
| | (b) No | 6 | 10.0% |
| | (c) Not indicated | 50 | 86.0% |
| 5. | Number of clients receiving services: | | |
| 6. | (a) Unknown | 43 | 62.0% |
| | (b) Less than 25 a year | 8 | 12.0% |
| | (c) 20-30 a year | 1 | 1.0% |
| | (d) 25-50 a year | 2 | 3.0% |
| | (e) 50-75 a year | 3 | 4.0% |

| ITEM | | NUMERICAL RESPONSE | PERCENTAGE |
|---|---|---|---|
| 7. | (a) 75-100 a year | 3 | 4.0% |
| | (b) 100-200 a year | 1 | 1.0% |
| | (c) 200-300 a year | 0 | ----- |
| | (d) 300+ a year | 4 | 6.0% |
| | (e) None | 4 | 6.0% |
| | Increase in clients: | | |
| 8. | (a) Yes | 25 | 35.0% |
| | (b) No | 27 | 37.0% |
| | (c) Not indicated | 20 | 28.0% |
| 4. | Is abuse/neglect system overloaded?: | | |
| 9. | (a) Yes | 29 | 40.0% |
| | (b) No | 9 | 13.0% |
| | (c) Not indicated | 34 | 47.0% |
| II. | SERVICES | | |
| 1. | Types of services: | | |
| | Preventive: | | |
| 10. | (a) None | 24 | 21.0% |
| | (b) Counseling | 25 | 20.0% |
| | (c) Family planning | 2 | 2.0% |
| | (d) Abortion counseling | 2 | 2.0% |
| | (e) Early identification | 2 | 2.0% |
| 11. | (a) Home visit | 5 | 4.0% |
| | (b) Parent groups | 10 | 9.0% |
| | (c) School programs | 3 | 3.0% |
| | (d) Educational programs | 9 | 8.0% |
| | (e) Day care | 2 | 2.0% |
| 12. | (a) Parent counseling | 5 | 4.0% |
| | (b) Teen-parent groups | 2 | 2.0% |
| | (c) P.E.T./Parenting skills | 5 | 4.0% |
| | (d) Group therapy | 2 | 2.0% |
| | (e) Voluntary foster care | 1 | .5% |
| 13. | (a) Adoptive services | 2 | 2.0% |
| | (b) Child management classes | 2 | 2.0% |
| | (c) Information & referral | 4 | 3.5% |
| | (d) Head start | 0 | ----- |
| | (e) Chemotherapy | 0 | ----- |
| 14. | (a) Educational therapy | 0 | ----- |
| | (b) Family life education | 1 | .5% |
| | (c) Funding | 2 | 2.0% |
| | (d) Legal aid | 1 | .5% |
| | (e) Medical care | 5 | 4.0% |

| ITEM | | NUMERICAL RESPONSE | PERCENTAGE |
|---|---|---|---|
| Outreach: | | | |
| 15. | (a) None | 48 | 60.0% |
| | (b) Home visits | 9 | 11.0% |
| | (c) Immunization & physicals | 2 | 2.5% |
| | (d) Follow-up | 5 | 6.0% |
| | (e) Satellite offices | 2 | 2.5% |
| 16. | (a) School programs | 7 | 9.0% |
| | (b) Family groups | 2 | 2.5% |
| | (c) Medical clinics | 2 | 2.5% |
| | (d) Other | 3 | 4.0% |
| Community Education & Professional Training: | | | |
| 17. | (a) None | 28 | 32.0% |
| | (b) Speakers bureau | 4 | 4.0% |
| | (c) PACER trainig/seminars | 18 | 20.0% |
| | (d) Staff in-service | 20 | 23.0% |
| | (e) Parent orientation & education | 5 | 6.0% |
| 18. | (a) Community education | 11 | 13.0% |
| | (b) Protective services training | 1 | 1.0% |
| | (c) Day-camp workshops | 1 | 1.0% |
| | (d) Other | 0 | ----- |
| 2. | Services Provided To: | | |
| Parents: | | | |
| 19. | (a) Counseling | 37 | 25.0% |
| | (b) Medical | 12 | 8.0% |
| | (c) Legal | 5 | 3.0% |
| | (d) Home visits | 3 | 2.0% |
| | (e) Parent groups | 16 | 10.5% |
| 20. | (a) Parent education seminars | 3 | 2.0% |
| | (b) Educational programs | 3 | 2.0% |
| | (c) Nutritional information | 1 | 1.0% |
| | (d) Psychological consultation | 3 | 2.0% |
| | (e) Speech therapy | 1 | 1.0% |
| 21. | (a) Physical therapy | 0 | ----- |
| | (b) Home-management | 2 | 1.5% |
| | (c) Employment/vocational | 2 | 1.5% |
| | (d) Health care | 2 | 1.5% |
| | (e) Transportation | 4 | 3.0% |
| 22. | (a) Shelter | 2 | 1.5% |
| | (b) Food | 2 | 1.5% |
| | (c) Housing | 3 | 2.0% |
| | (d) Utility payments | 1 | 1.0% |
| | (e) Prescriptions | 2 | 1.5% |

| ITEM | | NUMERICAL RESPONSE | PERCENTAGE |
|---|---|---|---|
| 23. | (a) Information & referral | 21 | 14.0% |
| | (b) Marriage counseling | 4 | 3.0% |
| | (c) Child management | 4 | 3.0% |
| | (d) Abortion counseling | 2 | 1.5% |
| | (e) No response | 11 | 7.0% |
| Children: | | | |
| 24. | (a) Counseling | 28 | 25.0% |
| | (b) Medical | 24 | 21.0% |
| | (c) Legal | 3 | 3.0% |
| | (d) Residential (foster) care | 8 | 7.0% |
| | (e) Hearing & Speech evaluation | 4 | 3.5% |
| 25. | (a) Day care | 4 | 3.5% |
| | (b) Dental health | 1 | 1.0% |
| | (c) Recreation | 1 | 1.0% |
| | (d) Adoptive homes | 3 | 3.0% |
| | (e) Food | 1 | 1.0% |
| 26. | (a) Placement | 1 | 1.0% |
| | (b) Group homes | 3 | 3.0% |
| | (c) Legal protection | 1 | 1.0% |
| | (d) Evaluation | 2 | 2.0% |
| | (e) Protection & removal | 3 | 3.0% |
| 27. | (a) Crisis counseling | 3 | 3.0% |
| | (b) Escort/companionship | 1 | 1.0% |
| | (c) Vocational counseling | 1 | 1.0% |
| | (d) Referral | 11 | 10.0% |
| | (e) No response | 7 | 6.0% |
| Families: | | | |
| 28. | (a) Counseling | 25 | 26.0% |
| | (b) Medical | 5 | 5.0% |
| | (c) Legal | 4 | 4.0% |
| | (d) Vocational training | 1 | 1.0% |
| | (e) Sibling counseling | 4 | 4.0% |
| 29. | (a) Family therapy | 13 | 14.0% |
| | (b) Adoptive studies | 3 | 3.0% |
| | (c) Food | 2 | 2.0% |
| | (d) Shelter | 3 | 3.0% |
| | (e) Utility payments | 1 | 1.0% |
| 30. | (a) Parent training | 4 | 4.0% |
| | (b) | -- | ----- |
| | (c) Traveler's Aid | 1 | 1.0% |
| | (d) Information & referral | 10 | 10.0% |
| | (e) No response | 20 | 21.0% |

| ITEM | NUMERICAL RESPONSE | PERCENTAGE |
|---|---|---|
| 3. Functions: | | |
| 31. (a) Identification | 52 | 18.0% |
| (b) Investigation | 29 | 10.0% |
| (c) Treatment planning | 33 | 11.0% |
| (d) Treatment services | 36 | 12.5% |
| (e) Referrals | 56 | 19.5% |
| 32. (a) Placement | 23 | 8.0% |
| (b) Follow-up | 19 | 7.0% |
| (c) Shelter | 13 | 4.0% |
| (d) Consultation | 3 | 1.0% |
| (e) Residential treatment | 4 | 1.5% |
| 33. (a) Medical planning | 8 | 3.0% |
| (b) Other | 2 | 1.0% |
| (c) Vocational training | 1 | .5% |
| (d) Funding | 0 | ----- |
| (e) None | 8 | 3.0% |
| 4. Services structured for the convenience of the client?: | | |
| 34. (a) Yes | 44 | 63.0% |
| (b) No | 13 | 18.5% |
| (c) No response | 13 | 18.5% |
| 5. Built-in restrictions: | | |
| 35. (a) Waiting lists | 13 | 12.0% |
| (b) Large caseloads | 10 | 9.0% |
| (c) Lack of follow-up | 2 | 2.0% |
| (d) Small staff | 13 | 12.0% |
| (e) Sexual restrictions | 2 | 2.0% |
| 36. (a) Financial restrictions | 13 | 12.0% |
| (b) Limited budgets | 6 | 6.0% |
| (c) Other | 15 | 14.0% |
| (d) No response | 13 | 12.0% |
| (e) None | 19 | 18.0% |
| 6. Publicity: | | |
| 37. (a) Very adequate | 14 | 21.0% |
| (b) Adequate | 24 | 36.0% |
| (c) Inadequate | 3 | 4.0% |
| (d) Limited | 14 | 21.0% |
| (e) None | 12 | 18.0% |

| ITEM | NUMERICAL RESPONSE | PERCENTAGE |
|---|---|---|
| I. COORDINATION | | |
| 1. Referral Agencies: | | |
| 38. (a) Family Counseling Center | 20 | 8.0% |
| (b) Hot Line | 3 | 1.0% |
| (c) SES | 42 | 17.0% |
| (d) Health Department | 11 | 4.5% |
| (e) Food Stamps | 1 | .5% |
| 39. (a) C&FCMHC | 29 | 12.0% |
| (b) Juvenile Welfare Board | 11 | 4.5% |
| (c) Private Practitioners | 6 | 3.0% |
| (d) Children's Medical Services | 3 | 1.0% |
| (e) Medical Community | 3 | 1.0% |
| 40. (a) Family Practice Program | 1 | .5% |
| (b) State Advocacy Committee | 1 | .5% |
| (c) Adult Mental Health | 15 | 6.0% |
| (d) HRS | 9 | 4.0% |
| (e) Schools | 9 | 4.0% |
| 41. (a) John 3:16 | 1 | .5% |
| (b) All-Children's Hospital | 6 | 3.0% |
| (c) PACER | 15 | 6.0% |
| (d) DYS | 3 | 1.0% |
| (e) Big Brothers | 2 | 1.0% |
| 42. (a) Police Athletic League | 1 | .5% |
| (b) Police | 6 | 3.0% |
| (c) Parents Anonymous | 3 | 1.0% |
| (d) Parent Aides | 1 | .5% |
| (e) Homemaker Services(FCC) | 2 | 1.0% |
| 43. (a) Family Consultation Team | 3 | 1.0% |
| (b) Courts | 3 | 1.0% |
| (c) Foster Care/Project Playpen | 4 | 1.5% |
| (d) Project Concern | 1 | .5% |
| (e) Medical Examiner | 1 | .5% |
| 44. (a) Lawyer Referral Service | 1 | .5% |
| (b) Free Clinic | 3 | 1.0% |
| (c) Other | 13 | 5.0% |
| (d) Adoption Agencies | 3 | 1.0% |
| (e) No Response | 7 | 3.0% |
| 2. Coordination-Information Sharing: | | |
| 45. (a) Yes | 48 | 70.0% |
| (b) No | 21 | 30.0% |
| Consent: | | |
| (d) Yes | 28 | 65.0% |
| (e) No | 15 | 35.0% |

| ITEM | NUMERICAL RESPONSE | PERCENTAGE |
|---|---|---|
| Specific Interagency Coordination Agreements: | | |
| 46. (a) Yes | 22 | 32.0% |
| (b) No | 47 | 68.0% |
| (d) Formal | 18 | 38.0% |
| (e) Informal | 29 | 62.0% |
| OVERALL VIEW | | |
| Agencies to handle cases: | | |
| 47. (a) SES | 47 | 57.0% |
| (b) Hotline(HRS) | 1 | 1.0% |
| (c) Juvenile Welfare Board | 8 | 10.0% |
| (d) PACER | 9 | 11.0% |
| (e) No response | 9 | 11.0% |
| 48. (a) Police | 2 | 2.0% |
| (b) C&FCMHC | 2 | 2.0% |
| (c) Medical | 1 | 1.0% |
| (d) Schools | 1 | 1.0% |
| (e) Other | 3 | 4.0% |
| Agencies to report cases: | | |
| 49. (a) Hotline(HRS) | 6 | 7.0% |
| (b) All agencies/people | 27 | 31.0% |
| (c) SES | 24 | 28.0% |
| (d) Schools | 7 | 8.0% |
| (e) Human Advocacy Comm-ttee | 1 | 1.0% |
| 50. (a) No response | 6 | 7.0% |
| (b) Juvenile Welfare Board | 1 | 1.0% |
| (c) Police | 2 | 2.0% |
| (d) Other | 6 | 7.0% |
| (e) Medical | 6 | 7.0% |
| Agencies to investigate cases: | | |
| 51. (a) SES | 53 | 61.0% |
| (b) Florence Nightingale Circle | 1 | 1.0% |
| (c) Human Advocacy Committee | 1 | 1.0% |
| (d) Police | 11 | 13.0% |
| (e) Schools | 3 | 3.0% |
| 52. (a) No response | 10 | 12.0% |
| (b) Juvenile Welfare Board | 2 | 2.0% |
| (c) State Attorney's Office | 1 | 1.0% |
| (d) PACER | 1 | 1.0% |
| (e) Other | 4 | 5.0% |

| ITEM | | NUMERICAL RESPONSE | PERCENTAGE |
|---|---|---|---|
| 4. | Agencies to provide treatment: | | |
| 53. | (a) Free Clinic | 1 | 1.0% |
| | (b) MD's | 2 | 2.0% |
| | (c) Counseling agencies | 9 | 10.0% |
| | (d) All agencies | 18 | 19.0% |
| | (e) Children's Medical Services | 2 | 2.0% |
| 54. | (a) C&FCMHC | 6 | 6.0% |
| | (b) UPARC/PARC | 1 | 1.0% |
| | (c) Florence Nightingale Circle | 1 | 1.0% |
| | (d) PACER | 11 | 12.0% |
| | (e) SES | 25 | 27.0% |
| 55. | (a) Hospitals | 3 | 3.0% |
| | (b) No response | 10 | 11.0% |
| | (c) Juvenile Welfare Board | 2 | 2.0% |
| | (d) Schools | 2 | 2.0% |
| | (e) Other | 1 | 1.0% |
| 5. | Abuse/Neglect Task Force/Committee: | | |
| 56. | (a) Yes | 46 | 66.0% |
| | (b) No | 7 | 10.0% |
| | (c) No response | 8 | 11.0% |
| | (d) Don't know | 4 | 6.0% |
| | (e) Maybe | 5 | 7.0% |
| 6. | Gaps/Problems of abuse/neglect system: | | |
| 57. | (a) Need for more SES staff | 17 | 9.0% |
| | (b) Increase money | 6 | 3.0% |
| | (c) Nutritional neglect | 1 | .5% |
| | (d) Waiting lists | 3 | 1.5% |
| | (e) Lack of communication | 13 | 7.0% |
| 58. | (a) Lack of coordination | 25 | 13.0% |
| | (b) Problem of poverty | 3 | 1.5% |
| | (c) Stigma/community attitude to abusers | 4 | 2.0% |
| | (d) Lack of proof for neglect | 1 | .5% |
| | (e) More experienced SES workers | 12 | 6.0% |
| 59. | (a) Inadequate agency reporting | 2 | 1.0% |
| | (b) More responsive legal system | 3 | 1.5% |
| | (c) Better treatment of neglect | 1 | .5% |
| | (d) On-going training | 3 | 1.5% |
| | (e) Prevention and early identification | 5 | 2.5% |
| 60. | (a) More services | 10 | 5.0% |
| | (b) Lack of 'shelter' | 1 | .5% |
| | (c) Immature workers | 2 | 1.0% |
| | (d) Lack of follow-up | 7 | 4.0% |
| | (e) Lack of half-way houses | 1 | .5% |

| ITEM | | NUMERICAL RESPONSE | PERCENTAGE |
|---|---|---|---|
| 61. | (a) Lack of adoption as alternative | 1 | .5% |
| | (b) No treatment | 1 | .5% |
| | (c) Low reporting from MD's | 1 | .5% |
| | (d) Lack of feedback | 6 | 3.0% |
| | (e) Clearer definition of abuse/neglect | 3 | 1.5% |
| 62. | (a) Lack of prevention | 1 | .5% |
| | (b) More services for parents | 4 | 2.0% |
| | (c) Lack of resources | 4 | 2.0% |
| | (d) Out-of-home placements | 1 | .5% |
| | (e) Long-term placements | 1 | .5% |
| 63. | (a) Over-loaded cases | 1 | .5% |
| | (b) Need for central agency | 6 | 3.0% |
| | (c) Disconnected system | 2 | 1.0% |
| | (d) Better organization | 7 | 4.0% |
| | (e) Too many Social workers on one case | 2 | 1.0% |
| 64. | (a) Clarification of law | 2 | 1.0% |
| | (b) Lack of public awareness | 9 | 5.0% |
| | (c) Prosecution problems | 1 | .5% |
| | (d) Single intake | 3 | 1.5% |
| | (e) No response | 7 | 4.0% |
| 65. | (a) Unknown | 2 | 1.0% |
| | (b) Lack of knowledge | 3 | 1.5% |
| | (c) Lack of sex education | 1 | .5% |
| | (d) Parenting education | 1 | .5% |
| | (e) Other | 2 | 1.0% |
| 7. | Duplications of abuse/neglect system: | | |
| 66. | (a) None | 29 | 40.0% |
| | (b) More coordination between agencies doing prevention & early identification | 14 | 19.0% |
| | (c) More coordination between SES and PACER | 2 | 3.0% |
| | (d) More coordination between SES and Police | 3 | 4.0% |
| | (e) No response | 15 | 21.0% |
| 67. | (a) Unknown | 8 | 11.0% |
| | (b) Confine resources | 1 | 1.0% |
| | (c) Dual reporting to SES & State Attorney | 1 | 1.0% |
| 8. | Strengths of abuse/neglect system: | | |
| 69. | (a) SES there when needed | 3 | 2.0% |
| | (b) People interested in curbing a/n | 10 | 8.0% |
| | (c) Awareness of rights of the child | 1 | 1.0% |
| | (d) PACER | 14 | 11.0% |
| | (e) Community education | 6 | 5.0% |

| ITEM | | NUMERICAL RESPONSE | PERCENTAGE |
|---|---|---|---|
| 70. | (a) Community awareness | 14 | 11.0% |
| | (b) There is a system | 11 | 9.0% |
| | (c) Quality human services agencies | 5 | 4.0% |
| | (d) Immediate response to retarded cases | 2 | 1.5% |
| | (e) Latchkey | 2 | 1.5% |
| 71. | (a) Parents Anonymous | 5 | 4.0% |
| | (b) Child management classes | 2 | 1.5% |
| | (c) Severe cases handled | 1 | 1.0% |
| | (d) Single intake | 3 | 2.0% |
| | (e) Hotline/reporting system | 7 | 6.0% |
| 72. | (a) Improved communication | 2 | 1.5% |
| | (b) Juvenile Welfare Board | 3 | 2.0% |
| | (c) No response | 9 | 7.0% |
| | (d) No strengths | 5 | 4.0% |
| | (e) Unknown | 9 | 7.0% |
| 73. | (a) 'Anonymous' reporting/confidentiality | 3 | 2.0% |
| | (b) Increased medical community involvement | 2 | 1.5% |
| | (c) Increased agency concern | 2 | 1.5% |
| | (d) Parent-Aide program | 1 | 1.0% |
| | (e) Family Consultation Team | 1 | 1.0% |
| 74. | (a) Good courts/judges | 1 | 1.0% |
| | (b) Quick response to reports | 1 | 1.0% |
| 9. | Completed Survey/Interview?: | | |
| 75. | (a) Completed survey | 63 | 83.0% |
| | (b) Incomplete survey | 13 | 17.0% |
| | (d) Interview | 56 | 74.0% |
| | (e) Non-interview | 20 | 26.0% |

NON-INTERVIEW GROUP

Questionnaires were sent to the following group with the request that the responses be filled in and mailed back to PACER.

Parents Without Partners
Ms. Gerry Clingan
P. O. Box 13541
St. Petersburg 33733

Clearwater Community Hospital
Administrator
1521 E. Druid Road
Clearwater 33516

Mease Hospital
Administrator
833 Milwaukee Avenue
Dunedin 33528

Tarpon Springs General Hospital
Administrator
Alt. Highway 19 South
Tarpon Springs 33589

American Red Cross
Mr. Ernest Rose
818 4th Street North
St. Petersburg 33701

American Red Cross, Upper Pinellas Chapter
Mr. Jim York
624 Court Street
Clearwater 33516

Alternative Human Service(Hotline)
Roy Miller
3761 5th Avenue North
St. Petersburg 33713

Alateen
P. O. Box 3013
Clearwater

Big Sisters
Susan Stanton
6428 123rd Avenue North
Largo 33540

Big Brothers
Harvey J. Benitez
647 1st Avenue North
St. Petersburg 33701

Boys Club of Pinellas Park
Mr. Chuck Parsons
8851 U. S. Highway 19
Pinellas Park 33565

Boy Scouts of America
Mr. Grant Wallin, jr.
11046 Johnson Blvd.
Seminole 33542

Clearwater Neighbors, Inc.
P. O. Box 1302
Clearwater 33517

Clinical Psychology Center
Dr. Mark Justice
1155 South Pasadena, Suite 225
St. Petersburg 33707

Community Service Foundation
Mr. Charles Mann
155 Bluff View Drive
Bellair Bluffs 33540

Diversified Educational &
Professional Services Center
P. O. Box 2345
Clearwater 33517

Jack and Ruth Eckerd Foundation
P. O. Box 4689
Clearwater 33516

Episcopal Counseling Service
Rev. William Bosbyshell, PhD
700 Bay Avenue
Clearwater 33516

Girls Club of Pinellas Park
Ms. Vera Thomas
7686 61st Street North
Pinellas Park 33565

Goodwill Industries Drug &
Alcoholism Treatment
1344 22nd Street South
St. Petersburg 33712

Homemakers' Upjohn, Inc.
Suite 214 Hulman Bldg.
3118 Gulf-to-Bay
Clearwater 33515

Information & Referral
Mr. Bill Vines
629 Franklin Street
Clearwater 33516

Ladies Center of Clearwater
600 Bypass Drive
Clearwater 33515

Lutheran Clinical Counseling
Center, Inc.
Dr. Stout
1976 East Bay Drive
Largo 33540

Legal Aid of Clearwater
J. W. Satterfield
422 So. Fort Harrison Avenue
Clearwater 33516

Pinellas Marine Institute
John W. Anderson
3101 Gulf Blvd.
St. Petersburg Beach 33706

Salvation Army
Brig. Harold Robins
340 3rd Street South
St. Petersburg 33701

Science Center of Pinellas County
Mr. Charles Gibbs
7701 22nd Avenue North
St. Petersburg 33710

St. Petersburg Women's Health Center
Ms. Janice Liggins
4401 4th Street North
St. Petersburg 33703

Family Practice Clinic
Bayfront Hospital
701 6th Street South
St. Petersburg 33701

Hubert Rutland Hospital
Administrator
5115 53th Avenue North
St. Petersburg 33709

Homemakers' Upjohn, Inc.
P. O. Box 13206
St. Petersburg 33733

Gulf Coast Jewish Family Services
Mrs. Gail
P. O. Box 12865
St. Petersburg 33733

Legal Aid Society of St. Petersburg, In
Robert J. Finck, Esq.
P. O. Box 262
St. Petersburg 33731

Mental Health Association
Ms. Jan Mallach
Suite 105 Madison Bldg.
9600 Gandy Blvd.
St. Petersburg 33702

National Foundation: the
March of Dimes
3144 34th Street North
St. Petersburg 33713

Police Athletic League
Mr. Jim Bowman
1801 5th Avenue North
St. Petersburg 33713

Salvation Army
Major Robert Bridges
400 No. Fort Harrison
Clearwater 33516

United for Youth
Mr. D. G. Drake
559 49th Street South
St. Petersburg 33707

Edward H. White Memorial Hospital
Administrator
2323 9th Avenue North
St. Petersburg 33713

Seminole General Hospital
Administrator
10200 Seminole Blvd.
Seminole 33542

St. Petersburg General Hospital
Administrator
6500 38th Avenue North
St. Petersburg 33713

Palms of Pasadena Hospital
Administrator
1501 Pasadena Avenue South
St. Petersburg 33707

Twin Mothers' Club
Mrs. Larry Schmidt
5285 40th Street South
St. Petersburg 33711

St. Petersburg Osteopathic Hospital
Administrator
401 15th Avenue North
St. Petersburg 33714

Pinellas County Lay Association of
Florida Diabetic Association
Mr. LeRoy Fiddler
504 Johns Pass Avenue
Madeira Beach 33708

## NON-INTERVIEW GROUP RESPONSES

The following of the Non-Interview Group returned the questionnaire:

The Ladies Center of Clearwater

Tarpon Springs General Hospital

American Red Cross: St. Petersburg

Homemakers' Upjohn, Inc.: St. Petersburg

*Homemakers' Upjohn, Inc.: Clearwater

Goodwill Industries: Suncoast, Inc.

Police Athletic League of St. Petersburg, Inc.

Legal Aid Society of St. Petersburg, Inc.

Lutheran Clinical Counseling Center

Big Sisters of Pinellas County, Inc.

*Hubert Rutland Hospital

*Palms of Pasadena Hospital

Big Brothers of Pinellas County, Inc.

Mease Hospital

University General Hospital of Seminole

St. Petersburg General Hospital

St. Petersburg Women's Health Center, Inc.

*Science Center of Pinellas County

Jack and Ruth Eckerd Foundation

*Returned questionnaire, but did not fill out responses.

## INTERVIEW GROUP

Questionnaires were sent to the following group with a letter informing them they would be contacted for a formal interview with one of the PACER staff.

Free Clinic
Sister Ann
433 7th Avenue North
St. Petersburg 33701

Carlton Manor
Jennie Adams
2901 Desoto Way South
St. Petersburg 33712

UPARC
Mrs. Bea Maurer
2199 Calumet Street
Clearwater 33515

PARC
Mr. Bert Muller
3100 75th Street North
St. Petersburg 33710

Project Playpen
Mr. Bill Neet
3455 1st Avenue South
St. Petersburg 33711

Juvenile Services Program
for Pinellas County
Dr. Pete Parado
3435 1st Avenue South
St. Petersburg 33711

Marriage and Family Counseling Service
Mrs. Nenabelle Dame
3455 1st Avenue South
St. Petersburg 33711

Pinellas County Dpartment of
Social Services
Mr. H. J. Angermeier
601 Court Street
Clearwater 33516

State Attorney's Office
Ms. Nyjola Grybauskas
3000 Central Avenue
St. Petersburg 33712

Children's Medical Services
Dr. Allyn Giffin
Ms. Cheryl Moore
535 9th Avenue South
St. Petersburg 33701

Free Clinic
Ms. Jane Gravel
201 W. Rogers Street
Clearwater 33516

PAR Drug Treatment Programs
Mrs. Shirley Coletti
2400 9th Street South
St. Petersburg 33705

Florence Nightingale Circle, Inc.
Ms. Alice Williams
P. O. Box 15001
St. Petersburg 33733

Pinellas Youth Homes System, Inc.
R. C. Henry
6468 5th Avenue South
St. Petersburg 33707

Juvenile Welfare Board of Pinellas County
Dr. Raymond L. Edwards
3455 1st Avenue South
St. Petersburg 33711

Community Youth Program
Lakeview Presbyterian Church
Ms. Elithia Stanfield
1310 Lakeview Avenue South
St. Petersburg 33705

Children's Home Society of Florida
Ms. Betty West
5201 Central Avenue
St. Petersburg 33709

Florida United Methodist Children's
Home
Nancy Streed
3375 34th Street North
St. Petersburg 33713

Child & Family Comprehensive
Mental Health Center
Dr. Raymond Sleszynski
4040 Central Avenue
St. Petersburg 33711

Pinellas County Sheriff's Office
Detectives Harper and Rusher
250 Ulmerton Road SW
Largo 33540

St. Petersburg Police Department
Division of Youth Services
1300 1st Avenue North
St. Petersburg 33705

Clearwater Police Department
644 Pierce
Clearwater 33516

Family Counseling Center
Mr. Wesley Jenkins
928 22nd Avenue South
St. Petersburg 33705

Developmental Center
Dr. Mack Hicks
105 5th Avenue NE
St. Petersburg 33701

TIPS
Ms. Judy Meisner
Roser Park Pupil Services
535 9th Avenue South
St. Petersburg 33701

Headstart--CFRP
Mr. George Farrow
St. Petersburg Center
1344 22nd Avenue South
St. Petersburg 33705

John 3:16 Mission
John 3:16 Cook
1027 Central Avenue
St. Petersburg 33711

Childbirth & Parent Education
League of Pinellas County
Sharon Moorhead
3201 26th Avenue North
St. Petersburg 33713

Young Women's Residence
Mrs. Eileen Poister
901 7th Avenue South
St. Petersburg 33705

Latchkey--Child's Park
Mrs. Betty Osborne
3940 18th Avenue South
St. Petersburg 33711

Latchkey--Safety Harbor
Mrs. June Unger
Safety Harbor Elementary
535 5th Avenue North

Largo Police Department
B. B. Skaggs
305 First Avenue SW
Largo 33540

United Way of Pinellas County
Mr. Carl Lash
2639 9th Street North
St. Petersburg 33704

District Mental Health
Mr. Gordon Denham
800 49th Street North
St. Petersburg 33710

Catholic Social Services
Phyllis Stapleton
4215 Central Avenue
St. Petersburg 33711

License Board of Pinellas County
Ruth Jefferson
3455 1st Avenue South
St. Petersburg 33711

Pupil Services
Catholic Schools of St. Petersburg
Mr. Bernard Schneider
P. O. Box 15108
St. Petersburg 33733

Pinellas County Headstart
Vince Chiarelli
1344 22nd Avenue South
St. Petersburg 33705

Girls' Clubs
Nancy Burke-Murphy
Suite 135-C
1301 Seminole Blvd.
Largo 33540

Adult Mental Health
Dr. Edward Meares
630 6th Avenue South
St. Petersburg 33701

Latchkey--Lealman
Mr. Arthur Jones
4001 58th Avenue North
St. Petersburg 33709

Pinellas County Health Department
Dr. George Dame
County Health Commissioner
500 7th Avenue South

Pinellas County Health Department
Ms. Sara Potter
500 7th Avenue South
St. Petersburg 33701

Juvenile Division/Circuit Court
Judge Jack Page
14500 49th Street North
Clearwater 33520

Juvenile Division/Circuit Court
Ms. Pat Barnard
14500 49th Street North
Clearwater 33520

Donald Macdonald, M.D.
1510 Barry Street
Clearwater 33516

All-Children's Hospital
Alan Porter: Social Services
801 6th Street South
St. Petersburg 33701

St. Anthony's Hospital
Miss Theresa Ryan: Director of Nursing
601 12th Street North
St. Petersburg 33701

St. Anthony's Hospital
Mrs. Bobbie Dyne: Emergency Room
601 12th Street North
St. Petersburg 33701

Sun Coast Osteopathic Hospital
Dr. L. Pettyjohn, D.O.
2025 Indian Rocks Road
Largo 33540

Bayfront Medical Center
Kenneth Swanson: Administrator
701 6th Street South
St. Petersburg 33701

Bayfront Medical Center
Ms. Pat LaGrue
701 6th Street South
St. Petersburg 33701

Bayfront Medical Center
Emergency Room Physician
701 6th Street South
St. Petersburg 33701

Pinellas County Health Department
Mrs. Mary Ann Davis, RN
Supervisor: Community Nursing Service
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St. Petersburg 33701

Juvenile Division/Circuit Court
Judge Robert F. Michaels
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Clearwater 33520

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St. Petersburg 33701

All-Children's Hospital
Dennis Sexton, Administrator
801 6th Street South
St. Petersburg 33701

All-Children's Hospital
Louis Alarcon: Medical Records
801 6th Street South
St. Petersburg 33701

St. Anthony's Hospital
Sister Gladys Sharkey: Administrator
601 12th Street North
St. Petersburg 33701

Sun Coast Osteopathic Hospital
Kenneth Whisenand: Administrator
2025 Indian Rocks Road
Largo 33540

Sun Coast Osteopathic Hospital
Miss Mary Miller: Social Worker
2025 Indian Rocks Road
Largo 33540

Bayfront Medical Center
Mrs. Norma Clair
701 6th Street South
St. Petersburg 33701

Bayfront Medical Center
Gordon Gipson: Social Services
701 6th Street South
St. Petersburg 33701

Morton Plant Hospital
Tom Sawicki: Assistant Administrator
323 Jeffords
Clearwater 33516

Morton Plant Hospital
Ms. Joan Flick
Social Services
323 Jeffords
Clearwater 33516

Morton Plant Hospital
Dr. John Bell: ER Physician
P. O. Box 6230
Clearwater 33517

Pinellas County School System
Mr. Joe Eidson: Area II Superintendent
8401 131st Street
Seminole 33540

Pinellas County School System
Mr. Lee R. Benjamin
Area IV Superintendent
2425 66th Street North
St. Petersburg 33710

Ms. Virginia Schifferl
Adult Home Economics
City Center for Learning
850 54th Street South
St. Petersburg 33711

Pinellas County School System
Monty Campbell
ESEA Center
2349 23rd Avenue South
St. Petersburg 33712

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Deputy District Administrator
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P. O. Box 20007
St. Petersburg 33742

John Trott
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St. Petersburg 33742

Mildred Forbes
HRS--District V
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St. Petersburg 33742

Jean Lewis
HRS--District V
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St. Petersburg 33742

Morton Plant Hospital
Ms. Sally E. Wolfer
Director of Nursing Services
323 Jeffords--WITT3
Clearwater 33516

Pinellas County School System
Mr. Eric Whitted: Area I Superintendent
1000 Holt Avenue
Clearwater 33515

Pinellas County School System
Mrs. Leila Davis: Area III Superintendent
4600 Haines Road
St. Petersburg 33714

Pinellas County School System
Glenn W. Kranzow: Supervisor
School Pupil Services
1895 Gulf-to-Bay Blvd.
Clearwater 33515

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Dr. Gus Sakkis
Superintendent of Schools
P. O. Box 4688
Clearwater 33518

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HRS--District V
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Cary Bible
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St. Petersburg 33742

Cleo Griffin
HRS--District V
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Julie Christian
HRS--District V
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St. Petersburg 33742

Ted Hanscomb
HRS--District V
P. O. Box 20007
St. Petersburg 33742

Pinellas County School System
Irving Warrick: Social Worker
School Pupil Services
1895 Gulf-to-Bay Blvd.
Clearwater 33515

St. Cecelia Elementary
Sister Mary Patricia Plumb
400 South Hillcrest
Clearwater 33516

Sun Coast Osteopathic Hospital
Mabel Costine: Medical Education Department
2025 Indian Rocks Road
Largo 33540

Pinellas County School System
Mary Jenkins: Principal
Blanton Elementary
6400 54th Avenue North
St. Petersburg 33709

Mr. Steve Perizanin
c/o Jim Waters
Dixie Hollins High School
4940 62nd Street North
St. Petersburg 33709

## INTERVIEW GROUP RESPONSES

The following of the Interview Group were interviewed by PACER staff and their responses recorded on the questionnaire:

St. Petersburg Free Clinic, Inc.: St. Petersburg

St. Petersburg Free Clinic, Inc.: Clearwater

Carlton Manor

PAR Drug Treatment Programs

Upper Pinellas Association for Retarded Children(UPARC)

Pinellas Association for Retarded Children(PARC)

Florence Nightingale Circle, Inc.

Project Playpen

Juvenile Services Program for Pinellas County

Marriage and Family Counseling Service

Children's Home Society of Florida

Pinellas County Department of Social Services

Florida United Methodist Children's Home

State Attorney's Office

Child and Family Comprehensive Mental Health Center (3)

Children's Medical Services (2)

Pinellas County Sheriff's Department

St. Petersburg Police: Youth Division

Largo Police: Juvenile Division

Clearwater Police Department: Juvenile Division

United Way of Pinellas County

Family Counseling Center

District Mental Health Board

Child and Family Developmental Center

Catholic Social Services

Teen-Age Information Program(TIPS)

License Board of Pinellas County

Child and Family Resource Program

John 3:16 Mission

Pinellas County Headstart

Young Women's Residence

Girls' Clubs of Pinellas County

Adult Mental Health Clinic

Latchkey Services for School Age Children in Pinellas, Inc.

Pinellas County Health Department

Donald Macdonald, M.D.

All-Children's Hospital

St. Anthony's Hospital

Sun Coast Osteopathic Hospital

Bayfront Medical Center

Morton Plant Hospital

Juvenile Court (2)

Ms. Virginia Schifferl: Adult Home Economics

Jean Lewis: Social and Economic Services(HRS--District V)

HRS--District V (2)

Pinellas County School System: Glenn Kranzow

Pinellas County School System: Irving Warrick

Blanton Elementary: Mary Jenkins, Principal

St. Cecelia's Elementary

Pinellas County School System: Steve Parazanin

Catholic Schools of St. Petersburg: Pupil Services

Juvenile Welfare Board of Pinellas County

Pinellas County School System: Monty Campbell

APPENDIX I

Speeches and Other Written Materials

## Speeches and Other Written Materials

Most of our speeches and training presentations were made extemporaneously or from minimal notes. Those few which were written are included in their draft forms.

Copies of pamphlets, etc., are attached. These items are included in the original only, as we do not have enough copies of some pamphlets to append to all copies of the report. Anyone desiring specific copies of any item should contact Charlene Bennett at the Juvenile Welfare Board, and we will try to fill the request.

Forms and other data pertinent to specific program components are included under the component appendices.

KEYNOTE SPEECH
MAY 20, 1977

We decided to title this "We've Only Just Begun" because our society is just in its infancy of engaging the problem of child abuse. The problem has existed for centuries maybe thousands of centuries, but was never really recognized as a serious problem until the last 20 years. A major effort is being made nationwide and multiple communities are in various stages of developing a systematic method of attempting to cope with the problem. Pinellas County is somewhere on the continuum of progress and no community anywhere can really lay claim to a sophisticated system which responds consistently and effectively to evidences of child maltreatment, much less acts definitively to prevent it.

What we want to say here is a few words about the state of the art in Pinellas County and attempt to outline future directions to which we might attend. First I would like to list the assets and liabilities for child abuse which exists in Pinellas County.

1. Social Service Complex - We have the typical compendium of agencies and services, a good complex of programs - has much to offer the phenomenon of child abuse, plus the added funding resource of JWB. But most of these agencies and services play no planned role in the child abuse problem, have a tenuous committment to it, and consciously engage it on intermittent occasions only.
2. Mandated Service - We have a satisfactory child protection law in Florida which unfortunately receives a fairly conservative interpretation at most local levels. In Pinellas County the mandated agency consolidation is a distance from fulfilling its charge. It worst of all is hampered by operating in marked isolation, partially by result of its own actions and particularly because of being scapegoated by the remainder of the social service community.

3. Special Services and Individual Efforts - Our community has bright pockets of services here and there in which employees are particularly sensitive to the problem of child abuse and who attempt to bring their service to bear on the problem. They are not necessarily well known for this function throughout the community. They are numerous committed persons who have verbalized their desire to contribute to the solution of child abuse. Some of them are in our mandated agency, some of them are in other social service agencies, and some of them are so-called lay persons. They are perhaps one of our more hopeful assets but they feel frustrated because they have no sense of a forum through which to work and no sense of guidance. They are ready to be tapped if they can find a suitable way to communicate.

4. Communication Channels - It is difficult to find clear cut assets in the area of communications. But we do feel that our community has been displaying some tentative efforts toward better communication, and hopefully this is a trend which may gain momentum if we all support it at each opportunity. This problem is not unique to us, it is is standard everywhere. For instance, the amount of time that most Child Trauma Teams across the nation report was required for them to reach an effective stage of operation was two years. Why? They say because of the very human problem of turfdom prevented their listening to each other or valuing each other enough to communicate and apparently some caring is the investment necessary for good communication. - I recently had occasion to participate in an exercise amongst professionals from many states. Sitting with our own disciplines only, we were asked to list adjectives which very candidly described our opinions of several other specific disciplines such as police, private

social services, public social services, attorneys, the medical community, etc. When the lists were revealed to the entire group, we were shocked to see ourselves reflected in those adjectives. Without exception, every list was a series of indictments of one profession against another. In each instance, it was not until the bottom of each list that we occasionally saw a positive or complimentary word. Our instructor capped off the exercise by saying "If you feel this way about each other, how do you expect to work together. Is it any wonder you avoid communication?". ~~Every~~ ~~Since~~ times this has been done the result was the same and if we did it in this room today it would not be different. The point being, it is time we recognize that our failure to work closely toward solutions is based primarily on our feelings for each other and that if we are to fulfill our responsibilities in this area, we must design some forced interactions which will gradually dispel the distrust and improve our perceptions of each other. Some of us are hoping that some possibilities for doing just this will be one of the results of today's seminar.

That is a brief summary of assets - liabilities.

Now, I would like to list some of the directions in which the resolution of child abuse is heading nationwide and suggest that is only a matter of time before these things come to Pinellas County, some being already here in various stages. I suggest these are backdrops against which we can judge our current programs. Orientation will become more and more preventive. The corrective emphasis of dealing with abuse after the fact does not appear to have made a dent in the problem. A system which forces people to accept accusation, direct or implicit, before accepting services, prevents to a great extent their use of services. What we will be doing is offering a variety of services to everybody on a very positive basis, much as a department store offers

products, with a client choosing his own rehabilitation path without paying homage to several professionals along the way. You may say that this will not work, but I say the current system does not work and I do know that people buy nicely packaged products more readily than anything else. Steps in this direction are the likely future course.

I think this includes the probable diversion of money from corrective into preventive activities initially. At this point it is hard for people to make the necessary break in thinking that allows available money to go from corrective services into preventive ones. Some of us recently heard what seems to be the only likely solution. Dr. Ray Helfer of Denver Team fame is now saying that we must tithe - meaning actually take 10% of money away from corrective services, letting the chips fall, and redirecting that money toward prevention. That sounds like heresy to some but he feels it would pay off in about five years and give us the courage and evidence to fund prevention more fully. Since then more and more people are saying it is only a matter of time until it begins to happen.

Future directions

1. Our definition of child abuse and neglect will alter from the current accusatory ones to something which will allow necessary family intervention on a services oriented basis. Instead of defining abuse and neglect in terms of an act or a failure to act on the part of a caretaker, we ~~would~~ will focus on the condition of a child. We will be able to list physical and behavioral characteristics of children which will identify them as unprotected or undernourished children - or children in need of services and ultimately simply children with needs. The solution to their problems then would be to meet those defined needs and no longer base our actions on something a parent did or did not do.
2. Greater involvement of community - if anything is becoming more accepted

now that child abuse is everyone's problem (a) because of all our own imperfections as parents putting all parents somewhere on a child abuse continuum, (b) because it is strictly by accident that some people were lucky enough to be born into relatively non-abusive atmosphere's and therefore strictly by random chance that some of us are child abusers and some are mostly positive parents, (c) in other words, we're all part of the human race in which no person is an island, to misquote John Donne. We need the involvement of everyone and especially the "normal" to point out those who really feel no great attraction to the field of child abuse. Why? Because unfortunately we people who gravitate to the helping professions are by and large unusually insecure people whose own needs are great and though our strong desire to help is very genuine, our strong personal needs often hamper taking the objective steps toward effective rehabilitation which need to be taken. I am convinced that the people with the most to offer our field are those outside it, those leading successful satisfying lives in other endeavors. Already such a person here and there is being drafted into service. We should welcome this, lean on these people, use them for strength in improving our programs. In this same vein, I should also point out it is being outmoded in many parts of our country to think of one agency as being responsible for the problem of child abuse. They cannot do it alone and it should not be expected to take this direction of change in this area is clear cut and it will some day happen in Florida. Some of us would like to see it propelled. Florida law is no different from that of other states whose laws are being interpreted so as to allow the mandated agency to both delegate and share its responsibility with the community. And if we have problems with such interpretation in Florida then the law can be changed if anyone wants to give more than lip service to this inevitability.

3. Lastly, may I say that we are very encouraged by the "sunshine" movement in our country. The new emphasis on honesty, accountability, expression of honest opinion, and dealing from the top of the deck is encouraging.

Lets hope it will have a gradual positive effect on making social service programs responsive to their goals and encouraging to each of us who must play a role.

I hope that what I have said here helps set the stage for each of you to make very honest contributions in your workshops today. But I also hope it doesn't encourage seriousness at the expense of humor Because we also want to have some good fun, relax a little and we hope that you eat well.

CHILD ABUSE: THE RULE, NOT THE EXCEPTION

Child abuse is a subject which some people avoid, with which some people are fascinated, and which most feel unwilling to confront in its full ramifications. I would like to begin this paper with a backdrop of the history of the important role of punishment as a method of rearing children. Severe physical punishment has always been standard; forms of infanticide were common in all early societies and many of them were quite explicit about the fact that children could be disposed of in a variety of manners if they were not wanted; the Bible has had much influence with its dictum, "spare the rod and spoil the child"; savage beatings for misbehavior and driving out evil spirits have been common throughout history; early Massachusetts law imposed the death penalty on unruly children; in ancient Rome and England and America, children were routinely mutilated to be used for begging. And we are all aware of the inhuman use of children during the period of industrialization and of the savagery of the slave days. Children are still killed or abandoned to death in this country, particularly in New York, where just last year almost 250 babies were found in garbage cans.

One thing is clear as we review the history of child care. Children were not particularly welcome members of society; they were financial and disciplinary burdens; and of less importance and utility than animals, particularly when they were small. What I am exemplifying is that children were a frightening hazard to

the lives of adults during most of the earth's history and good child care has been the exception, not the rule. Starvation, abandonment, neglect to the point of death, various forms of physical torture and punishment were the normal lot of many children.

So how did we reach the point where child care standards are so very high that all I have mentioned seems like a bad dream? It seems to have begun with the industrial revolution which eventually led to the existence of the nuclear family. The economic situation improved and more people were able to experience a thread of stability in their lives. More and more the primary caretakers of children became women who stayed home while husbands went to work and who could devote a little more effort to improving child care through trial and effort. Standards of care rose because children were seen as having some intrinsic value of their own and this is the standard which was thrust upon all of society. For a period of time in this country in the 20th century very little was said about cruelty to children and the assumption was made that all children received good care except for isolated situations which became public knowledge. Only recently has it become obvious that there is something wrong with the nuclear family and that child abuse has continued to flourish in this atmosphere.

In the 1940's and 50's, physicians began to be aware of what has become known as the battered child syndrome, the children who

are presented in emergency rooms with broken bones, malnourishment, burns, marks from severe beatings, etc. Only recently have some mothers been able to admit that they have periodically injured their children in moments of uncontrolled anger. In spite of our so called age of plenty, when labor saving devices abound, when futures seem secure, when recreation is plentiful for many, children are still viewed as a burden by many and those many are once again becoming verbal about it. We have rediscovered child abuse; we have rediscovered that there are many people who do not want children; we have rediscovered that child care really is a burden for which many people are unprepared.

The knowledge and concern which currently exists has come about probably because of diminishing economic dependence of women on men. During the years when we mistakenly thought child abuse was rare, it appears that women were just non-verbal about their problems because they had no alternative way of life and dared not admit to injuring a child or not living up to the new standards because of feared repercusions to their economic security.

Now that women have more access to education and means of self-support they feel freer to admit that child care is not necessarily a rewarding experience; some can say they do not want children at all, some can say they do not chose to accept the responsibilities of child rearing unless the husband shares more fully in those responsibilities, some are deserting their families, and more and more of them are verbalizing that they view child care as

a burden in some sense or another. Concommitant with this development has been the fact that men, and young husbands in particular, are assuming more and more of the daily routine of child care; it is no longer routine for women to receive custody of the children after a divorce (courts are beginning to award custody to fathers and some divorcee's are voluntarily giving custody to their ex-husbands). And in the last few years we have seen a significant rise in child abuse perpetrated by men.

With this as background, let us now move into a description of the typical or classic child abuser in order to have a base for discussion. The so-called classic abuser for whom abuse becomes a pattern in child care is basically an immature person who cannot form give and take relationships with other persons because their own unmet needs are too great. I am going to outline eight characteristics of abusers which I hope will communicate to you a picture of the total cycle of child abuse and how it gets passed from one generation to another.

1. Child abusers have very poor self concepts. They have a deepseated sense of inadequacy because they were not made to feel worthwhile during their formative years. In each case, they were abused themselves, if not physically, them emotionally, and it is their own emotional deprivation which leaves them unprepared to play a nurturing role in the life of a child.

2. Generally, their lives are very ungratifying. Minor events can throw them into severe insecurity and a vague sense of needing something in thwir environment to reassure and gratify them. Some of them are constantly miserable and unsatisfied.

3. Because of this brittleness in temperament, they are super sensitive to criticism or anything that they might interpret as disapproval from others. They have lived with criticism, withdrawal of approval and affection as children. Now as adults they perceive criticism everywhere. In an effort to resolve this they tend to seek out others much like their own parents, hoping that those others will redeem the failed parents by heaping love and acceptance. They put their worst foot forward demanding to be redeemed. Instead they get the same critical reactions which they got from parents.

4. As a consequence, they routinely select lovers and spouses from the population who have the same problems as they. They cannot interact with mature individuals. Although they often do not recognize the defects in each other, once they marry, they find that neither truly meets the other's needs and they both live very precipitously with the constant hope that their lives will improve. They often remain unhappily married because their sense of inadequacy condemns them to believing that they are unloveable and not likely to be able to find another person to care for them. It is not unusual for them to fall into a passive dominant relationship which neither can alter. One person may make excessive demands

on the other as a way of structuring the environment to meet his own needs; the dominant person controls by use of criticism and withdrawal of love when the partner steps out of the established expected pattern. The passive partner, fearing the criticism, strives submissively for the expected perfection. Both, however, are constantly wishing for improved performance on the part of the other and for escape from their sense of bondage to the unsatisfactory relationship.

5. Into this a child is born and both turn to the child for gratification - to fill the love void in their lives - to create in them s sense of security - in brief, to replace the loving parent figure they never had. Essentially, the child becomes the parent and is expected to meet the adult's needs. Every parent does this to a certain extent - child abusers have an overdose of it.

6. These parents have unusually high expectations of the child because of their own great needs. They view the child as a source of criticism - the child makes them vulnerable. It is very important that the child perform up to expectations on every count; otherwise he may expose them as bad parents and therefore unlovable. If the child cries, this becomes an accusation; he is unhappy, ergo they are not doing something right, ergo they are a bad parent. The same things can happen when the child wets, when he refuses to eat, when he throws a temper tantrum, when he doesn't sleep through

the night, when he doesn't sit up as soon as the neighbor's child did, when he resists toilet training, ad infinitum. His normal babylike behavior becomes a criticism to the parent, a failure to love, and the child becomes another dissapointing parent figure. The same old anger and hurt is produced in the parent who loses control and lashes out at this child who represents his last hopes in life for a satisfying relationship.

7. Child abusers are very isolated persons. Because of their experiences and emotional deficiencies, these people do not trust other people and cannot turn elsewhere for help. They live their isolated lives and tend to become more isolated as their problem grows.

8. They rear their children just as they were reared - in an atmosphere of non-achievable demands, criticism, withholding of love, and sometimes, physical abuse. They doom their children to being the same kinds of parents that they are and that their parents were before.

These eight characteristics fit the classic child abuser. There are many people who deviate from the classic syndrome. There are those who become temporary abusers during a particularly stressful period in their lives. They may function fairly well under normal conditions but disintegrate as the result of a death in the family, a divorce, a major illness, etc. Many abusers appear quite normal - so normal that friends, physicians, etc.,

refuse to believe it when an incidence of child abuse occurs in their home. They run the gamut of psychiatric disturbances: a few are psychotic; relatively few are sadistic. All of them are quilt ridden and tend readily toward depression many have a history of suicidal behavior. In whatever category they fall, most of them are difficult to help because of their inability to trust. However, with the right amount of persistence by a non-threatening individual, many of them can respond to overtures for help and new approaches are constantly being attempted with relative degrees of success. I will not add anything further about the nature of child abusers except to emphasize that the problem is not confined to any race, sex, or socio-economic class. People who are unable to nurture children are everywhere. Emotional abuse is common throughout our society. Some potential abusers are fortunate in that they are able to avoid the daily routine care of children and therefore never fully demonstrate their deficiencies in this area. At this point I would like to add a few words about child abuse in the middle and upper economic strata. Many people in these groups are ungiving, unnurturing kinds of individuals who have great unmet needs. However, because of the work ethic in which they are raised, their access to education, and the greater reality of potential economic success, they become highly motivated, driven individuals. Success and affluence become substitutes for caring parents and children become incidental to the goals, taking their importance primarily from the degree to which they can enhance

their parents image and share in those goals. The typical family in this setting is one in which the mother pretends interest in child care, farms it out to others to the extent that the family can afford it, and gradually becomes secretly resentful of their unsatisfactory role in the family. Alchoholism is a common result of this situation. Meanwhile the father works long hours trying to reach his success goal, uses ~~a office~~ home a psychological service station which he can only tolerate for brief periods, and has little tolerance for the demands of the children particularly while they are small. Children do not gain a sense of self-worth from this kind of atmosphere; the damage to them is more subtle and more easily disguised. They may not often be physically abused but the emotional abuse is equally damaging. The improved economic condition and consequent ability to purchase substitute child care and good education is what makes the difference between them and the more blatant child abusers. Were their economic stability removed from them, their child care patterns would be same as poorer members of society. The extent to which they become greedy and fight the sharing of their wealth is the same extent to which they contribute to the continuation of theproblem of child abuse in general. Child abuse is everyone's problem.

We will not go into detail here about the various forms of abuse and the nature of treatment techniques, but we will now return to the major thrust of this paper which I hope has already

begun to me made. The essential concern is the fact that child care is in an unfortunate state in this country, that child abuse in one form or another is of serious proportions, and that there is every indication that the problem will get worse before and if it gets better.

Let's return in conclusion to the subject of the nuclear family in America and its failure to routinely provide a satisfactory vehicle for child care. Depression and self-dissatisfaction are common amongst us. People are more and more demonstrating their inability to maintain lasting relationships with other individuals as evidenced by the divorce rate, by unhappy marriages that do not result in dovirce, by both fathers and mothers who desert their committments to their children and by the desperate fear of making committments which is the single most salient characteristic found in the large numbers of people who flock to the various singles groups which are now multiplying in our society. These many unhappy and anxious people are not able to properly nurture children and provide the stability they need. Their state of mind results in behavior which exhibits many of the characteristics of the classic child abuser. More and more people are having difficulty finding a reason for having children; more are electing not to have children. It is becoming more acceptable to recognize that you might not be an ideal parent. Zero pupulation growth is not due simply to improved birth control but to the fact that committment to

children and to the long term relationships they need is less appealing and the stigma for admitting to such is rapidly decreasing. To a certain extent this is good because some potential child abusers may never become parents. However, if it is as I suspect, that the majority of people are not prepared for parenthood, what does this portend for the future? I think it portends that the children who are born will continue to be abused in some form, that people will continue to exhibit child abuser characteristics but will do so more openly than in the past - in essence, that child abuse is and will continue to be the rule, not the exception.

PACER
PARENT AND CHILD EFFECTIVE RELATIONS

juvenile welfare board of pinellas county 813/822-6661
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executive director
Raymond L. Edwards, ACSW, Ph. D.

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Charlene G. Bennett

# Establishing a Chapter of Parents Anonymous in Pinellas County

## Telephone Number

PACER's first step was to attempt to get the name of one parent who was interested in forming a group and who we thought might be willing to take the telephone calls of potential members and other inquiries. Having a private party take calls is a help since it tends to frighten fewer people away than does an agency telephone number. However, if you cannot locate such a person immediately, it is still possible to utilize an agency phone number with some degree of success until a parent's number can be obtained.

## Meeting Place

We selected the YWCA in St. Petersburg to use as a meeting place because of its central location, availability of parking, meeting room facilities, and, most important, a nursery. The YWCA had a nursery already in operation for YWCA members attending evening activities for 25¢ per child.

The availability of child care is imperative since many parents would not be available to attend without that. We were fortunate to discover this ready-made arrangement since we had originally figured upon the necessity of recruiting volunteers from the local community college child care program or from the teen volunteer program at the Red Cross.

Interestingly enough, the YWCA does plan to replace its paid babysitters with volunteers from the same resources. The YWCA then plans to develop a more sophisticated educational program for these children (mainly pre-schools). We plan to join forces with them in training their volunteers.

Originally we attempted to avoid securing a church as a meeting place since we had thought that this might tend to evoke guilt or anxiety in potential Parents Anonymous members who might be scared off. However, The National Chapter of Parents Anonymous does not believe this to be valid. They feel parents are receptive toward the use of churches as meeting places since frequently they have good nursery facilities, although it must be made clear that Parents Anonymous is not church-affiliated.

Meetings generally last two hours and are held in the evenings. Our chapter meets on Thursdays, between 7:00 p.m. and 9:00 p.m.

## First Meeting and Publicity

We invited Jo L., of the Parent Chapter of Parents Anonymous, to arrange to visit St. Petersburg for the purposes of publicity and in order to conduct the scheduled first meeting. Though Parents Anonymous does have a Department of Health, Education & Welfare grant in order to fund their travel expenses, they had already utilized that portion of the grant allotted for the Florida area. Therefore, we did have to cover Jo L's expenses. Since we felt that Jo L might draw people to the first meeting, we built the publicity around her visit as our focal point.

PACER is made possible through a grant from the Office of Child Development, the Community Services Administration, and the Bureau of Health Services Research.

Fortunately, St. Petersburg is a community which is receptive and co-operative in dealing with social problems. We were able to schedule Jo L on four television shows and three radio shows, plus coverage by local television news. We also arranged three interviews with feature writers of our three major newspapers. These were all scheduled within two days which meant an extremely tight schedule.

Other Means of Attaining Membership

We contacted the Division of Family Services, and other social service agencies in the community about three or four weeks prior to the first meeting, informing them of the organization and trying to get names of potential members. It is very important to explain the purpose of Parents Anonymous, and not to disguise it as "child management" or "classes".

Sponsor

Originally we were under the impression that only a parent with an abuse problem could initiate a Parents Anonymous group. If that parent, and a few other members decided a sponsor was needed, they would seek one out. However, this is not the case.

Any professional can initiate a group of Parents Anonymous. However, it is wise to obtain a sponsor who is not connected with a protective services or a court-affiliated agency since it is too threatening to potential Parents Anonymous members.

Initially, a sponsor takes on the role of group leader until a group leader can emerge from the chapter. As a current co-sponsor, I would say that our role is compressed basically in helping the parent to stay on-topic and to express his feelings, and of being extremely supportive. Currently, as co-sponsors, we are taking a somewhat active role, but as the group becomes more cohesive and as the true leader emerges, our roles will diminish. After three or four meetings, the leader will become more obvious and responsibility will be transferred on a gradual basis.

A sponsor is not reimbursed financially for his services; his time must be donated. However often his agency may make comoensatory time available to him.

Formation of the Group

At the first meeting eighteen people attended. Some, however, were referred under false pretences of going to a group for "frustrated parents", or to a child management class. Consequently, some of these parents were scared away after the first meeting when they were exposed to so many gut-level reactions and profanity from parents with extreme anxiety.

At the second and third meetings, six parents attended, which was a huge drop in attendance; however, the interaction was very productive, and mutual problem-solving began occurring. A genuine core-group seems to be evident.

A chapter of ten is described as the most workable size; since we did obtain the telephone numbers of parents present at the first meeting; one Parents Anonymous member is contacting them in order to draw them back into the group. Hopefully, at some point in the future, we will be able to get enough group members to split the group into two chapters.

Summary

We are currently planning on-going publicity of Parents Anonymous which includes radio spots, posters, and flyers; hopefully, this will help the chapter to grow.

Thus far, the experience of being involved in Parents Anonymous has been most gratifying since individuals are already experiencing change in this brief time.

Additional Information

Additional and more detailed information is available from:-

Regional Representative, Parents Anonymous,
Linda Hayes,
221 Redwood,
Birmingham, Alabama 35210

Telephone: (205) 592-3303

This information was prepared by Carol J. Hofen, Assistant Director, PACER.

PACER
PARENT AND CHILD EFFECTIVE RELATIONS

juvenile welfare board of pinellas county 813/822-6661
3455 first avenue south • st. petersburg • florida 33711

executive director
Raymond L. Edwards, ACSW, Ph. D.

project director
Charlene G. Bennett

BROADCAST: Immediate

SUBJECT: PARENTS ANONYMOUS

Do you scream and yell at your children and feel like you're losing control? Come to Parents Anonymous meetings. Parents Anonymous cares about parents and wants to help. There are no fees, dues, or memberships. Complete confidentiality is guaranteed. The Clearwater/Largo Chapter meets every Thursday afternoon from 1 to 3 p.m. at the Skycrest United Methodist Church, 2045 Drew, Clearwater. Free child care is provided. Call Thom at 822-6661 for more information.

SUBMITTED BY: Thom H. Shuman/Planning Technician/Project PACER
Juvenile Welfare Board of Pinellas County
3455 First Avenue South
St. Petersburg, Florida 33711

Tel: 822-6661, Ext. 221



PACER is made possible through a grant from the Office of Child Development, the Community Services Administration, and the Bureau of Health Services Research.

PACER
PARENT AND CHILD EFFECTIVE RELATIONS

juvenile welfare board of pinellas county 813/521-1853
4140 forty ninth street north • st. petersburg • florida 33709

executive director
Raymond L. Edwares, ACSW, Ph. D.

project director
Charlene G. Bennett

PUBLIC SERVICE ANNOUNCEMENT

BROADCAST: Immediate

SUBJECT: Parents Anonymous

The Clearwater/Largo chapter of Parents Anonymous meets every Wednesday evening from 7 - 9 p.m., at the Child & Family Comprehensive Mental Health Center, 908 South Fort Harrison, Clearwater. Free child care available.

Parents Anonymous is a self-help group of parents who meet to discuss mutual problems, frustrations, and feelings in raising their children. There are no dues, fees, membership rolls - confidentiality is guaranteed. If you are experiencing difficulties in raising your children, come join us.

For further information, contact Thom at 521-1853 or 867-0793.

SUBMITTED BY:

Thom M. Shuman,
Planning Technician,
PACER Project,
Juvenile Welfare Board of Pinellas County,
4140 - 49th Street North,
St. Petersburg, Florida 33709

Tel: 521-1853, Ext. 254

#3

BROADCAST: Immediate

SUBJECT: PARENTS ANONYMOUS

Are you angry and frustrated with your children but have no where to turn? Parents Anonymous cares about parents. Meetings of the Clearwater-Largo Chapter are held every Thursday afternoon from 1 until 3 p.m. at the Skycrest United Methodist Church, 2045 Drew, Clearwater. The group is completely confidential. Free child care is provided. Call 822-6661 for further information and ask for Thom.

SUBMITTED BY:

Thom M. Shuman/Planning Technician/Project PACER
Juvenile Welfare Board of Pinellas County
3455 First Avenue South
St. Petersburg, Florida 33711

Tel: 822-6661, Ext. 221

## DEPENDENT CHILDREN

This presentation represents a combining of two of last year's subject areas:

(1) Child Abuse and Neglect

(2) Adoptions and Foster Care

In essence, the subject matter is expanded to include the entire dependent child category. The recommendations under this category are broken into the following areas - adoptions, foster care, child abuse and neglect, prevention - and represent for the most part a compilation of the thinking of several individuals and several agencies. These are what we considered the most significant of numerous recommendations which could be made.

Subject Area 1: Adoptions

First, we want to highlight one legislative advance which was called for at last year's Legislative Workshop - namely, the need for subsidized adoptions. House Bill 3212 providing for the subsidized adoption of special needs children became effective October 1. We thank our delegates for their various contributions to that legislation. Our community's professionals now have one primary area of concern about Florida's adoption law and that is the discrepant requirements which exist for independent as opposed to licensed agency adoptions. Without exception, we all continue to feel that the independent adoption does not provide adequate safeguards for child or adoptive family and our recommendation today is that Florida do what most states have done - eliminate the independent adoption - with one permissable exception - that of step parents adopting the child of a spouse.

Subject Area 2: Foster Care

Again, we can point to a significant step forward taken by the Florida Legislature in the past year and I refer to Senate Bill 866, commonly known as the foster care tracking bill and providing for court review of all children remaining in foster care beyond a six month period. Our 1976 recommendations regarding foster care are as follows:

(a) The tracking law just referred to might be strengthened by establishing automatic court initiated review rather than placing the burden of filing petitions upon the various agencies.

(b) Still more realistic payments need to be made to foster parents. And, in conjunction with this, a comprehensive program of medical and dental services for foster care children is in order. Much is being said these days about institutional abuse and neglect and we can correctly state that most of this nation's foster children are victims of medical and dental neglect; Florida's children are no exception. We place priority on this recommendation.

(c) Provision should be made for extensive and appropriate training of foster parents, and ideally, such training should be a prerequisite for obtaining a foster home license.

(d) With regard to purchase of foster care services between the state agency and other service providers - progress is being made. We recommend, however, that the legislature explore the problems surrounding implementation of purchase of services and determine whether or not they might be able to effectively intervene.

Subject Area 3: Child Abuse and Neglect

(a) We recommend complete revision of Chapters 39, 827 and 409 as they relate to both dependency and delinquency. We have no time to outline details but all familiar with these laws find that they contain conflicting instructions and suffer from varied interpretations. A complete overhaul is in order and there are many concerned professionals in Pinellas County who stand ready to make contributions to that overhaul. We are very pleased that legislative wheels are apparently already turning to make this revision possible and offer our assistance. (b) With specific reference to child abuse we wish to emphasize that one step only remains for bringing Florida Law into compliance with the Mondale Statute which distributes federal monies

to states. Our legislature made compliance almost a reality in 1975 with the new child abuse statute effective in July of that year - and the addition of a guardian ad-litum provision for all litigated custody cases would complete the picture. Although the current level of federal funding to the states is not large, the possibility of larger future amounts exists, particularly since the bill's major proponent, Walter Mondale, will soon be in a position to further its intent.

(b) Action needs to be taken which would provide a better funding base for provision of services to abusive families and other families with dependent children. We will never break the cycle of abuse and neglect unless this, along with prevention, is given priority.

(d) Child protection staff ratios at HRS should be revised to meet Child Welfare League standards (one caseworker to twenty families). Only the legislature is in a position to impact the current overload situation at HRS.

(e) Training and education in child abuse and neglect needs to be established as a priority both for professionals and for the public. In addition, education of the public by HRS regarding their function and proper utilization of their services is suggested.

(f) The state is recommended to revise its standard of direct assistance for children to 1976 levels and to provide for automatic cost of living increases thereafter based on the federal consumer price index. Recommendation is also made that 100% of standards be automatically and continuously paid. Unless this minimum standard is enforced, recipients must either choose to live without necessities or they must find money through other and by implication illegal means.

(g) Our last and admitedly controversial recommendation under this subject area is that Florida opt to lead the nation in an in-depth assessment of our service delivery system to dependent children and their families. We are implying in this recommendation that the system hampers its effectiveness in

many ways, not the least of which is the manipulative approach to the client population and its probably unrealistic expectation that clients accede passively to its significant decision making role in their lives.

I would like to suggest that the service delivery system suffers from the same dynamics which it ascribes to its clientele - such as isolation, confusion, poor self-concept, inadequate resources, lack of trust, fear of communication beyond its barriers, fear of annihilation, and limited ability to share. If this be true, then it is with considerable guilt that we continue in a judgemental and directive posture with those we purport to help. We need change before we can demand client change - indeed before we can understand the ingredients in change.

A systematic study and self-analysis is recommended for purposes of developing an altered and responsive service delivery system. Such thinking is being articulated more and more and since the changes are inevitable, we recommend that Florida lead the way.

Subject Area 4: Prevention

(a) Our primary recommendation this year is that enactment of legislation that will incorporate mandatory parent education in our public and private school curriculum from grades K through 12. We hope the priority of this recommendation speaks for itself.

(b) In addition, we recommend mandatory premarital education and mandatory pre-divorce counselling in all cases where children are involved.

This list is by no means exhaustive but it represents our conception of a beginning and minimal effort in the realm of prevention.

This concludes our committee's recommendations on dependent children.

# An Extra-System Approach

# to the

# CHILD ABUSE PROBLEM

Elizabeth Royer, Program Coordinator
PACER

American Association of Psychiatric Services for Children, Inc.
San Francisco, California
November 14, 1976

PACER (Parent and Child Effective Relations) is one of the evelen original deomonstration child abuse and neglect programs funded by a grant from the Office of Child Development, the Community Services Administration, and the Bureau of Health Services Research. The grant was made to the Juvenile Welfare Board of Pinellas County, Florida in April, 1974; the project director was hired in August, 1974, the five other staff members were recruited by the project director in September, and PACER became operational as a preventive child abuse program in October, 1974, six months after the grant was received.

PACER was conceived as being a preventive program and as such, was not designed to assume a case management function or to focus on corrective treatment in identified abuse cases. However, some of PACER's components fall into the corrective category and are meant to enhance the existing system.

The concept of PACER and subsequent grant application by the Juvenile Welfare Board was an outgrowth of a county seminar on child abuse in which a cross section of community agencies agreed that effort should be made to secure funding for a county-wide project. At the time of the community child abuse seminar preceding the PACER grant application, child abuse was considered a serious problem in Pinellas County. During the 1973 reporting year, 1148 possible child abuse cases had been reported to the Hot Line. These reports were 40% above the national reporting rate. Experience indicates that approximately 60% of overall complaints are valid. At the same time, the county Protective Services reported that about 45 families reported per month were not investigated for varying reasons. This was the background information leading to the PACER grant application.

Before presenting specific information on the PACER program, I would like to present information about the Juvenile Welfare Board of Pinellas County. Historically, the Juvenile Welfare Board was established

by a bill passed in 1945 by the Florida State Legislature and approved through a local referrendum in 1946 by the voters of Pinellas County. Its members are made up of five lay members appointed by the governor, the vice chairman of the Board of County Commissioners, two judges from the Juvenile Court, and the County Superintendent of Schools. Revenues to the Juvenile Welfare Board are generated by a millage on real estate. Essentially, it is a county agency with its own Board of Directors, although the revenues do not go into the county general fund, and the County Commissioners do not approve the Juvenile Welfare Board budget.

It is the only body of its kind in the U.S. designed to maintain services to youth as a matter of priority by continuing surveillance of needs and resources, by experimentation, by evaluation of results, by demonstration, and by public education. The Juvenile Welfare Board provides supporting funds in whole or in part, to most of the child serving agencies in Pinellas County.

The Juvenile Welfare Board recognized the need of providing special services to abused children and their families a number of years before there was general acceptance of the need for protective services throughout Florida. In 1961, the Juvenile Welfare Board established a protective services program as a part of the child care and protection activity of the Division of Family Services of the Department of Health and Rehabilitative Services, the state mandated agency receiving and investigating child abuse and neglect complaints. The Juvenile Welfare Board continued to fund three counselor positions in protective services after 1971 when state appropriations for protective services became available throughout the state.

Florida was one of the first states to have a state wide Hot Line for handling child abuse and neglect reports. The Hot Line was started in 1971. It is a toll free number, listed in all telephone directories under

the emergency numbers and is manned by social workers 24 hours a day, seven days a week. For two years after the Hot Line was started, the State Advertising Council promoted the Hot Line and reporting child abuse in all media, and the obvious result was that protective services throughout the state were impacted with reports. The state Hot Line is currently in Tallahassee and is the chief source of child abuse referrals for most counties. The state Department of Health and Rehabilitative Services recently had a major reorganization under legislative mandate, and in a few counties, such as Pinellas, there is a 24 hour intake for handling child abuse reports. The logistics of developing a prompt response on a state wide basis and maintaining a central registry broke down after HRS reorganization and the continued impaction of child abuse reports to the Hot Line.

Pinellas County is a long (about 40 miles) urban county on the central west coast of Florida. Total population is about 650,000 with the greatest number of people either being over 65 years of age or under 25. The public school system is a county system with a school population of approximately 80,000 students. Florida continues to be a rapidly growing state in population, and ten of the eleven high schools are on double sessions.

The full complement of PACER staff is six. This includes a director, assistant director, two program coordinators, research technician, and a secretary. Three of the staff have Master's Degrees in Social Work, two of whom worked in protective services in Ohio and the other was Director of Social Work in a general hospital in Ohio before moving to Florida. One staff member was in education and the research technician is a recent graduate with a major in the social sciences. There has only been one staff turnover early in the beginning of the program. This is unusual among the other federally funded child abuse programs and has resulted in good staff

morale (even though the program terminates March 31, 1977. and excellent continuity of the program and preventive services. This has also resulted in credibility and visibility in the county as staff has been able to develop good working relationships with the child serving agencies. PACER met resistance from the public agencies responsible for protective services, and gradually over the past two years most of the resistance has disappeared, and protective services staff have viewed PACER as a program with services to supplement, and not duplicate, existing programs in the treatment plan rather than being in the community to monitor services provided abusing families by the official agency.

PACER staff has available to them consultative services of the Juvenile Welfare Board Community Services Team for which indirect costs are paid by PACER on an on-going basis.

The overall goal of PACER is to significantly reduce the incidence of child abuse among Pinellas County families and to achieve this by maintaining the child in his home whenever possible. Objectives include:

A. Primary Objectives

1. To provide educational programs and community information aimed at the public in general and at high risk groups in particular.
2. To provide training programs for professionala and para-professionals for the purpose of increasing their knowledge of child abuse.neglect and of their profe-sional responsibility.
3. To enhance case finding and treatment planning for both children and their families through the development of child trauma teams, law intern program, and a child trauma medical registry.
4. To develop new treatment services for identified abusers/ neglectors and potential parents at risk, including Parents

Anonymous and Parent Aides.

5. To initiate a procedure for early identification of high risk families and a method for follow-up and referral to service resources.

B. Secondary Objectives

1. To provide the impetus for a coordinated community system of combined preventive and corrective efforts aimed at minimizing child abuse and neglect in Pinellas County.
2. To improve the overall data base regarding the subject of child abuse so as to facilitate improved prevention, detection and treatment of the condition at the county, state, and possibly national level.
3. To assess the cost of hospital care of abused children and their families both before and after the establishment of child trauma teams.

It was hoped to achieve the just described PACER goals and objectives by focusing completely on prevention with the implementation of several program components. These components are:

Parents Anonymous

Parent Aides

Child Management Classes

Training and Education

Hospital Trauma Team

Maternity Ward Monitoring (Changed to New Parent Information service in October, 1975).

Legal Intern Program

Data Collection and Program Evaluation

I will briefly describe the components indicidually including implementation problems and current status of each of the components.

Parents Anonymous

Parents Anonymous is a self-help group of parents who feel that they may abuse or who are actually abusing their children. PACER currently has two Parents Anonymous chapters in Pinellas County, one in St. Petersburg which has been meeting weekly since Decem'er, 1974, and ~~the~~ a chapter in Clearwater started in September, 1975. PACER has provided a sponsor to each group and baby sitting is also provided. The availability of child care is imperative since many parents would not be available to attend without available child care. Junior College students in the Human Services program have provided child care as part of a field work experience. Baby sitters for the Clearwater chapter are paid.

In establishing the first Parents Anonymous chapter, PACER's first step was to get the name of one parent who was interested in forming a group and who would be willing to take calls of inquiry. Having a private party take calls is a help since it tends to frighten fewer people away than does an agency telephone number. This was very important to PACER's first chapter as PACER's calls go through the Juvenile Welfare Board switchboard. Fortunately, such a parent for the St. Petersburg chapter was located quite readily, the wife of a serviceman who had previous knowledge about Parents Anonymous.

A central, accessible meeting place is essential, and the St. Petersburg chapter meets at the YWCA. The Clearwater chapter meets at the Child Guidance Clinic. Both groups are currently meeting in the evening although the Clearwater chapter initially met in the afternoon. This did not prove convenient because of transportation problems for one car families, and the other advantage of the evening meeting is that both parents could attend sessions.

Jo L., of the Parent Chapter of Parents Anonymous was invited to Pinellas County, and her visit was planned to coincide with the first meeting of the St. Petersburg chapter. I would like to point out that all the media has been cooperative in promoting Parents Anonymous from the very beginning of the project, and during Jo L's two day visit, she did four TV shows, three radio shows, and had three interviews by feature writers of the three major newspapers. At the first meeting 18 people attended. Some, however, were referred under false pretenses of going to a group for "frustrated parents", or to a child management class. Consequently, some were scared away after the first meeting when they were exposed to so many gut-level reactions and profanity from parents with extreme anxiety.

Attendance at Parents Anonymous meetings varies with many parents "dropping in and out", depending on how things are going at home. There is always a nucleus of two or three parents with other parents coming and going depending again on their need for the support sustained from the other parents. A chapter of ten is described as the most workable size.

I am sure that you would recognize that Parents Anonymous is not a treatment module for all abusing parents. Parents have to have some insight and be motivated to benefit from a self-help parent group.

As previously mentioned, the media has done a very good job in promoting Parents Anonymous. Referrals to Parents Anonymous have been self-referrals, (especially after media promotion), and agency and community professional referrals. Unfortunately, there have not been t many referrals to Parents Anonymous from Protective Services. Posters regarding Parents Anonymous meetings in laundromats, public health clinics, junior colleges, hospital emergency rooms, churches, etc., have been a fairly successful way of continuously promoting Parents Anonymous for targeted groups of young parents especially. Many of the parents attending Parents Anonymous are also concurrently receiving services from other community agencies. The Florida

child abuse law permits Juvenile judges to court order parents to Parents Anonymous meetings, but so far, only one or two parents have been ordered to Parents Anonymous.

I would like to conclude the comments about Parents Anonymous by making some observations about the sponsors. Sponsorship is exhausting and draining. Parents frequently need to be supported throughout the week by long telephone calls around crisis situations. Sponsors do much outreach with the parents, and both of the chapter sponsors are usually providing transportation for parents to chapter meetings. One of the sponsors somewhat facetiously commented that the Tampa Bay area Parents Anonymous chapter sponsors should form an S.O.S. group. (Save out Sponsors). Finally, Parents Anonymous needs continual promotion for recruitment.

Parent Aides

"Parenting the parent" is the focus of this component of PACER. Pne staff member is assigned full time to the recruitment, training, and supervision of volunteer parent aides after they have been assigned a family who is having problems coping. The parent aide who is only reimbursed for mileage, serves as a friend to the parent and is available when stress reaches a peak in a family. Tje parent aide can hopefully offer alternatives for dealing with the problems which will prevent physical harm to the children. A parent aide has the role of being a friend whose chief responsibility is to the parent. The parent aide is in the home for the parent, not the child or children, although they will benefit. The parent aide has often been referred to as an advocate who helps the parent find relief before the crisis occurs.

The basic requirement for a parent aide is that of a stable, mature person who has had adequate parenting and feels secure enough to offer support to another without being judgemental. Most of the PACER parent aides have had a fair degree of success parenting their own children and have a reservoir of experience to draw upon.

PACER Basically has two groups of parent aides - one down county and the other up-county. The down-county group was recruited first, primarily through the media. An initial group of ten volunteers was screened and then given ten hours of child abuse training over a four week period. About nine months after the first group of parent aides was trained and assigned to families, another group of ten volunteers was recruited up-county. The second group was recruited mainly through Religious Community Services, an organization of thirty congregations up-county whose chief purpose is to provide community service through the churches by identifying unmet community needs and working collaboratively on solutions. After the completion of the basic training, the parent aide is assigned to a family, most of which were referred from Protective Services. Supervision of the parent aides and on-going training is quite time consuming. It is quite important that staff support be provided the parent aide, espacially after the family assignment. While it is true that most of the families referred to parent aides are usually known to at least one community agency and the parent aide may be communicating with that agency worker about the family functioning, it has been PACER's experience that PACER staff support of the parent aide is crucial, especially in some of the multi-problem families referred to parent aides. If the family is known to several agencies, the PACER staff person also provides a coordinating function.

The parent aides are almost universally agreed that this is a most challenging, rewarding, and demanding type of volunteer activity but very satisfactory when they can observe changes in family behavior. One other unanticipated result has been parent aide total family involvement with the family who is having problems coping.

The following are some observations from one of the parent aides regarding her experiences.

"I became aware of PACER through a church member and with mixed

feelings began attending meetings. PACER staff provided 20 hours of basic training plus the training you have received here. More recently we completed 20 hours of empathy training. During this time I was able to deal with my feelings and gain tremendous insight into unhealthy parenting. I believe all parents are potential abusers. The difference between myself and client, I have the ability to cope thanks to education and my many bail out processes.

As the mother of six I can relate to feelings of anger, frustration, even hostility and rejection, so it is easy to be an understanding and not condemning, and I am able to accept her where she is. I allow myself to become a bail out process, to become a friend, to listen and to make myself available. I allow her to lean on me until she has learned or restored self-control. This has proven effective. In time X gives me her total trust and shares her most gut level feelings with me. Much of this sharing remains confidential but I do pass on to the social worker relevant information. X is aware of this and accepts it. I truly feel she is relieved when I do this because I have shared what she has wanted to share but couldn't because of some fear or other. I do not propose to share her problems but make suggestions which may allow her to gain a new perspective. X also learns the value of calling me at the time she is losing control. We talk and she gains composure.

X and I will always be friends, our friendship is special. I have seen a rose bud struggle to bloom and succeed.

As a parent aide I have gained knowledge and understanding of our social agencies. In ignorance I was quick to note their shortcomings, now I can better understand their efforts and limitations and the workers have my greatest respect. I have also become a resource means for the community, for persons in need.

My husband and children encourage my involvement and thay have learned to become involved. They have been most tolerant of inconveniences

day and night. My girls have made the greatest sacrifice of all, they have given me the right to monopolize the telephone."

# Child Trauma Teams

Of all the components, the child trauma teams were the most difficult to start — and generally for a variety of reasons.

PACER operates in a county where there is little inter agency communication as the result of case conferencing and collaborative case thinking was foreign to most professionals, the mental community raised the issues of confidentiality which proved to be a real deterrent in the way the first teams operated, and in Florida child abuse laws specify that the parents of the protective services worker — any agency that the official agency may share information only when another agency is involved in the case treatment.

There are two child trauma teams operating at the present time. The first one to become functional is basically a community trauma team which meets once a month in a 125 bed Children's Hospital in St. Petersburg. As previously mentioned, much professional and community momentum

2

~~was~~ to improve the county child abuse system was generated after years of community meetings. ~~Case~~ It was after the first seminar when a multi disciplinary team grew, shown was the key note speakers what ROGER was able to organize an actual functioning team. The leadership of a prominent pediatrician who was a semi retired because of a coronary was secured, and after many, many planning sessions, the first team was started.

Roger places a high person as a ~~missing~~ ~~link~~. The team consists of ~~Dept.~~ Protective Services workers, the ~~Dept.~~ Protective Service supervisor, the nurse that visit the case discussed by the team, ~~are~~ cases that are currently in the system, and many times the ~~known~~ Protective Services for some time and have become "problem" cases. Regular team members include a physician, protective service worker, hospital social worker, private lawyer, assistant State attorney, public health nurses, and ~~a~~ a social worker from the Children's Medical Services. There are other ~~professionals~~ professionals who serve as team members depending

on the case being presented. These include a school social worker, law enforcement officer, and representatives from other community agencies.

Team members, such as the physician or hospital social worker, who want to refer a case to the team refer the case to Pupil Personnel Services who then might bring it to the team. The advantages of this operational method of operation are obvious. It does not allow for hasty decision making by the physician which may not be in the child's best interest. By meeting with the child, parents, teacher, school nurse, social worker, and other professionals involved with the child, a more complete picture of the child's needs can be developed. Usually the child's parents and physician are invited to attend the meeting. Usually the child's parents do not attend. The team tries to meet at a time when the parents can attend

Training and Education

Training and education is probably the largest PACER component in terms of staff time and thrust into the community. PACER has the most extensive collection of child abuse audiovisuals, and it is the exceptional day when some of the audiovisuals are not being used in training and educational sessions. The audiovisuals are available on a loan basis, but the agency policy is that a staff member be along for discussion purposes.

An analysis of the referrals to the Hot Line showed that there was very professional reporting of possible abuse and neglect cases. Physicians accounted for about 1% of the reports in the reporting year preceding the federal grant, and the total health professions about 3 %..

Therefore, the health professionals were targeted as the first group of professionals for professional education during the first year of PACER operation. A fair degree of success was achieved.

Six of theeight hospitals in the county have had In Service programs on child abuse, varying in length from two hours to an all day seminar. Four of the programs were approved for continuing education credits forregistered nurses.

PACER has had two community child abuse seminars, attracting about800 community professionals and concerned citizens. At both seminars national leaders in the child abuse and neglect field have been the key note speakers. Local physicians were involved by being asked to serve as workshop leaders or panel moderators, and they became instantaneously knowledgeable about child abuse. The county medical society has co-sponsored our community seminars, and Florida Medical Association approval for continuing medical education credit hours has been received for the seminar. ~~Physicians response in taking advantage of the con-~~

"Child Management" classes

helping parents require better parenting skills was using ~~the~~ principles as a right priority. The Series was among ~~among~~ the couples who have come to Hawaii for a variety of reasons, but most important to this paper, the majority of families are on Hawaii, geographically isolated from families.

Because of the need for parenting classes on the Pinellas County Schools through the Community Involvement [illegible] was [illegible] capitalized on this priority need [illegible] the classes. [illegible] PACER paid for the [illegible] PET, and [illegible]

In January 1975 the classes were started in Pinellas County. The classes were open to [illegible] parents with [illegible] PACER paid for [illegible] in getting such assurance responsibility for the [illegible] about the classes. Word of mouth [illegible] also publicized the classes.

The classes were an instantaneous

LAW INTERN PROGRAM

A corrective PACER component is the Lw Intern program. A the time of the PACER grant, ptotevtive services did not have access to the use of legal representation through the State Attorney's office in the processing on contested dependency affadavits filed in Juvenile Court. This resulted in many poorlt prepared agency cases went to court. It was felt that a more coordinated system of legal process would be beneficial and the law intern program was developed to provide greater consistency and routine procedures which would facilitate rather than impede the use of the legal system by Protective Services.

A formal agreedent was entered into with theState Attorney's office and PACER whereby three law students from Stetson Law School were hired on a part timebasis ( a maximum of twenty hours a week). PACER paid the salaries, and the law students were recruited, screend and supervised by the State Attorney's office. The law intern helps prepaxxre the Protective Service cases for court on all dependency affidavits which are contested. Another provision of the agreement is that a staff attorney from the State Attorney's office would represent Protective SErvices at the actual court hearing.

The results of the law intern program have been better preparation and representation of the contested child abuse cases, and an Assistant State Attorney has become very very expert and sophistacated in the complexity of dependency affadavits. The law intern program has resulted in the processing of abuse and neglect cases in a manner that minimizes hostility and results in a treatment approach to parents and the insurance of safety for children.

One observation should be made that in a few cases that State Attorney and the Protective Services worker have not agrred upon the recommendations to the court. The other interesting fact is that as our projects nears its end and we are looking to the coommun ty to spin off components, this is probably the first one to be spun off, as the State Attorney's office is committed to the program, has seen much value to it, and will continue it.

Research and Evaluation

At the same time the eleven original demonstration grants were made, HEW contracted with Berkley Planning Associates to evaluate the eleven projects to try and establish what programs and services appear to impact the child abuse problem. What kinds of services and combinations of services appear to be effective? The research has meant periodic visits from Berkley, comparative site visit reports, and completion of numerous forms. The one problem with the forms is that basically they all were designed for they ten projects providing direct services to families and not for a preventive program.. This built-in provision for researsch and evaluation is one example where the federal government used some foresight as hopefully, the summative evaluation should have good information for communities as they look at their child abuse services.

# Summary

Federal funding for PACER ends March 31, 1977. Federal funding was secured for the third year of PACER's operations, and PACER, like several other of the current demonstration projects has chosen to operate until the money runs out, rather than reducing components or programs during the final year of the grant.

Work has begun on the components of the program to integrate all of the components to provide an ~~and coordinate a~~ unified ~~Program~~ approach to ~~Corrections~~ Rehabilitation.

Emphasis will be placed on continuing existing alternative services and programs, ~~and~~ in Pinellas County.

As previously mentioned, the Child Management Classes will be continued by the Adult Home Economics

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Schools and the Law ~~Outreach~~ Interns Program will be carried on by the State Attorney's Office through an L.E.A. grant.

Grant Arrangements is one of those ~~unquestionably~~ services which theoretically should operate outside the system

After two years of operation, we have a fairly ~~clear~~ picture as to which services are ~~clear~~ cut for operation outside the direct Service System while others must ~~clear~~ always work with the mandated ~~clear~~ or process. The monitoring use of ~~all~~ ~~clear~~ by clients cannot be risked upon in the resolution of the abuse/neglect problem and should be considered simply an alternative available for use by the small percentage of persons able to correct their ~~prior~~ problem without the supervision of the mandated system.

Parents Anonymous

This is one of those services which theoretically should operate outside the system - or at least on the periphery - because

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many persons who reach out to P.A. do so only because of its totally anonymous character. ~~Doctor~~ Hawens, the reality seems to be that it is necessary to associate it in some way with the system because it ~~upon~~ requires considerable dedication plus the kind of knowledge which comes from association with the system. Only the mandated system has the stamina and the degree of investment necessary for motivation to keep P.A. going ~~more~~ some of the adverse conditions which exist in [illegible] Corps, Task Force Orange and with the Army. By marriage and [illegible] a direct service program of the Family Welfare Bureau. Two sponsors meet the provisions for the two P.A. Chapters.

Parent Aides

Parent aides seem very inappropriately placed anywhere far from the mandated agency because coordination of cases becomes a problem and duplic

cation of effort means. Problems are minimized if one total service provides all the arms. Parent Aides are a valuable and important volunteer service and should be in considerable supply. PACER has demonstrated that Parent Aides can be recruited, trained, and supervised. It would be important for Parent Aides to be supervised by the same case worker in any given situation. It is very important that Parent Aides have the ~~same~~ kind of ~~support~~ and support ~~supervision~~ ~~as~~ professionals ~~receive~~.

The logical agency for Parent Aides would be Protective Services, but no ~~such~~ firm arrangement has been worked out yet. The Parent Aides could be recruited by the Volunteer Coordinator of the Protective Services although if Parent Aides are to be recruited in significant numbers, a full Parent Aide Coordinator would be desirable.

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## New Parent Information Services

The new Parent Information Service is an appropriate function for continuation in some form by FCB or FCB & secure monies. It is most client oriented and new problem oriented and falls clearly into FCB's current prevention focus. It is preventive not only of child abuse and neglect but of many other social ills. Above and beyond that, it is a whole area of parent education and early assessment to be appropriately handled by FCB and is the greatest important preventive [illegible] responsibility on the future. At the present time, this is an area component which we [illegible] in doubt.

## Training and Education

is to be continued by FCB. At the end of three years PACER will have proved a training and education for a large segment of the professional population and for much of the county's category in some form or another. There will be residual training needs and continuing effort in middle on

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the area of public education as well as consultation. At some point in the future DTRS may be able to assume a greater portion of the training function. Its training efforts should then take on a more complimentary nature, encouraging prevention and public awareness. It is likely, however, that DTRS would always be the primary repository of training materials.

C. Police news the end of its [illegible] it shows the water where all [illegible] previous impeding [illegible] of this class case is [illegible] reluctance to assume final responsibility. Decisions having [illegible] effects [illegible] based and agency protectiveness rather than sound treatment principles. The [illegible] available in Pinellas County is impressive, and [illegible] it is only sporadically being channeled into [illegible] neglect intervention or prevention.

It is PACER'S opinion that ultimately a case review process must be established to facilitate the

7/ Require for a comprehensive child abuse/neglect system of meaningful services available to parents and children at the time of the first abusive incident.